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An epidemiological study of maladjustment in childhood

by

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"Wisdom is rooted in watching with affection
the way people grow"

Confucius.

NEWCASTLE UPON TYNE : An aerial view from the southerly approaches. The University buildings and teaching hospital with the "Town Moor" beyond can be seen in the left background. (Photograph by courtesy of Newcastle Chronicle and Journal Ltd.)

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INTRODUCTION

The object of this thesis is to present an epidemiological[1] study of maladjustment in children drawn from a sample population. The work has been carried out as part of a more extensive longitudinal study of morbidity in childhood which has come to be known as the Newcastle Thousand Families Survey.

Before describing the work upon which this thesis is based I would like to describe briefly the historical development of the present concepts of maladjustment and the approach to its study and treatment. In order to appreciate the background of the present work it will also be necessary to give some account of the City of Newcastle, from which the sample was drawn, and of the development of the Thousand Families Survey.

CHILD GUIDANCE

The concept of child guidance in the sense of direction or redirecting the child's mental development is at least as old as Plato and is to be found in the writings of the earliest educationalists. Present concepts of maladjustment however have largely developed from the work of the late 19th century psychologists. Spencer, Bain, Galton

[1] "Epidemic" has been defined as "prevalent among the community at a special time" (The Concise Oxford Dictionary IVth Ed. 1951. O.U.P. London) The usage of the term epidemiology in its present context has developed largely in the past ten years and is discussed in "The Epidemiological study of Mental Illness and Mental Health" by Paul V. Lemkau (Am. Journ. of Psych. III, 801 - 9, May 1955)

and Sully were the pioneers of child psychology in this country and sought to apply their theories to the education and training of children.

In 1864 Galton opened his anthropometric laboratory in conjunction with the International Health Exhibition. He offered measurement of human form and faculty for the modest price of 3d. and asked parents to consider "whether it is worth your while to pay less than a shilling to have your boys and girls measured ..... either to learn their powers or to obtain timely warning of remediable faults in development". (Keir 1952) This work, sometimes described as the first child guidance clinic, was encouraged and extended by Sully who in 1893 became Professor of Mind and Logic at University College, London. Sully opened the first exclusively psychological laboratory in this country in 1896 with McDougall, and later Spearman, as Director. An active Education Section had already been established under Mitchell and teachers and others were encouraged to bring their difficult pupils to the laboratory for investigation.

With the Education Act of 1876, which made school attendance compulsory, it was soon apparent that many children were unable to reach the minimum educational standards laid down in the code of the Board of Education. This gave rise to considerable discussion among all concerned with the care and education of children on how methods could be devised for separating out and treating those who were "potentially imbecile, criminal, or insane".

The British Child Study Association, founded in 1893 by Sully with the support of teachers, inspectors of schools, and education officials, established a number of branches throughout the country which had an important influence on the thinking of educationalists and others - Sherrington was an early and active supporter. McDougall, whilst maintaining his University College appointment, obtained a part time readership in the University of Oxford and opened a small psychological laboratory there. At his suggestion, Keatinge, the Reader in Education, opened an informal centre, based on Galton's laboratory, to which teachers could send children for examination. Under McDougall and Keatinge Cyril Burt carried out studies on schoolchildren until 1907 when he was invited to become lecturer in psychology in Sherrington's Department of Physiology in Liverpool. In Liverpool Burt continued his work among backward, defective and delinquent children. The first Mental Deficiency Act reached the statute book in 1913, though in 1899 an enactment had provided special schools for children of sub-normal intelligence.

In 1913 the L.C.C. was stimulated by the Child Study Association and others to appoint a psychologist (Cyril Burt) for an experimental period of three years - this was the first appointment of a child psychologist by an official body. His terms of reference were wide for he was required to investigate and recommend suitable training or treatment

for individual children referred to him, to assist in the allocation of pupils to the most appropriate schools, to organise 'ascertainment surveys' to detect children needing individual examination, and to give general advice on the psychological aspects of problems or proposals before the Education Committee.

The emphasis up to this time had been largely on educational retardation and delinquency. Workers in these fields were mainly psychologists and sociologists, though some paediatricians had taken a particular interest in children who would now be called maladjusted. Dr. Hector Cameron's "The Nervous Child", published in 1918, was an important landmark in medical interest in the emotional disorders of childhood. Work on individual children had been largely through the schools and to some extent the courts; failure in adjustment which did not result in school difficulty or antisocial behaviour had received little attention despite the establishment of educational or psychological clinics.

Crichton-Miller in 1920 established the Institute of Medical Psychology (now the Tavistock Clinic) primarily for the treatment of functional nervous disorders in adults but children were soon receiving treatment there. During the early twenties several London Teaching Hospitals made provision for out patient consultations in psychiatric illness, again mainly for adults though some children were seen. The Maudsley Hospital opened for the treatment of neurosis in 1923 and from the beginning

gave special attention to the treatment of children. The present Child Guidance Clinic pattern was first seen in 1927 with the opening of the East London Child Guidance Clinic, established under Dr. Emanuel Miller by the Jewish Health Organisation. In 1928 the Commonwealth Fund made it possible to open the London Child Guidance centre with Dr. William Moody as Medical Director - the location of the clinic in the Canonbury district was selected because of the high incidence of delinquency there.

Other clinics opened in Glasgow, Aberdeen, Birmingham, Bristol, Sheffield, and Manchester, during the next decade. Birmingham, in 1932, had been the first local education authority to open a child guidance clinic, and by 1939 seventeen clinics were wholly maintained and five partly maintained by local education authorities. By 1952, 96 local education authorities were providing a child guidance service in addition to those provided by voluntary bodies and hospitals. In 1955 the Underwood Committee recommended that a comprehensive child guidance service should be available for the area of every local education authority.

In the United States of America development was on very similar lines, Cattell, after working with Wundt and Galton, returned to Pennsylvania as the first American Professor of Psychology, and a few years later, in 1896, Lightner Wilmer at Cattell's suggestion opened a psychological clinic on similar lines to that established by Galton.

Later Healy, as a result of his work with delinquents from the Juvenile Court, opened the Chicago Juvenile Psychopathic Clinic in 1909 and was largely responsible for the establishment of the Judge Baker Foundation in Boston in 1915. Initially, Healy relied upon co-operation from social agencies for details of the home backgrounds of his clients, but after the appointment of a social worker to the Boston Psychopathic Hospital in 1912, the Chicago Instutute and other organisations followed suit.

In 1910, Stanley Hall invited Sigmund Freud to give a course of lectures in America, and the work of Janet and Freud had a considerable influence on the thinking of American psychiatrists. Adolf Meyer who had already attempted to introduce the doctrines of the British evolutionists into American psychiatry, incorporated much of 'the new doctrine' into his own eclectic scheme. It is interesting to note that in England it was the psychologists who gave psychoanalysts a hearing whereas psychiatrists in the main firmly rejected their views.

Clifford Beers, who had been a patient in a mental hospital was convinced of the need for public pressure and education to achieve improvement in psychiatric services, and in particular improvement in the appalling conditions under which patients were detained in mental hospitals in the United States. In 1909 he founded the National Committee for Mental Hygiene. It was not however until about 1920 that the committee began to take a practical interest in the psychiatric needs of

children. Shortly after that time, financial aid from the Commonwealth Fund made it possible to organise a number of experimental child guidance clinics under medical supervision. Demonstration clinics were opened in 1922 in St. Louis and Norfolk, and these were the fore-runners of the 'team' clinics (Psychiatrist, Psychologist and Social Worker) which operate today. Within a few years clinics were operating throughout the United States. By this time America was the only country operating clinics on a team basis, and was leading the world in the development of psychiatric services for children.

In this country the influence of these developments was felt when in 1925 Mrs. St. Loe Strachey, an English juvenile court magistrate, visited the United States to study the function and operation of child guidance clinics and meet representatives of the Commonwealth Fund. On her return to this country she actively sought support for the establishment of clinics here and a representative of the Commonwealth Fund came to this country to report on the possibility of establishing a clinic in England. As a direct result of this report and Mrs. Strachey's efforts a number of social workers visited the U.S.A. in 1927 and were offered training in psychiatric social work with a view to opening clinics in this country. The Child Guidance Council, set up in 1928 by the National Committee for Mental Hygiene and the Central Association for Mental Welfare, accepted these offers "to encourage the provision of skilled treatment of children showing behaviour disturbance and early symptoms of disorder."

The developments just described took place against the background of an evident need which was becoming more obvious. Concerned originally with defect and delinquency, the broader view of the psychiatric needs of children was gradually gaining in emphasis. Today despite rapid improvement in the facilities for child guidance, waiting lists are full and most workers in the field remain overburdened with what is now regarded as 'routine' work. We are still lacking in precise information on the nature and incidence of maladjustment in the child population.

The use of the term 'maladjustment' dates from the 1920's and it has only been widely adopted in this country since the second world war. Though the reality behind the term has existed throughout history, it is only in recent years that the size and serious implications of the problem have been widely appreciated, or that it has become possible to attempt to affect them on any scale. Only as recently as the 1944 Education Act did the category of 'maladjusted pupil' appear among the schedule of handicapped children. These children are defined in the Handicapped Pupils and School Health Services Regulations, 1945, as 'pupils who show evidence of emotional instability or psychological disturbance and require special educational treatment in order to effect their personal, social, or educational re-adjustment.' This definition, though adequate for administrative purposes is of little help in the identification of maladjustment in particular children and is confined to children who can and should be treated within the educational system.

Burt (1952) suggested that for educational purposes a maladjusted child may be defined as 'one whose adjustments to the situations of his everyday life are less adequate than might reasonably be expected from a child of his mental age and whose conditions or circumstances therefore require special study or treatment.' Elsewhere he defined the unstable child as one in whom 'the instincts and emotions are developed to an excessive degree and the child's behaviour and intellectual processes are as a result unbalanced.' He distinguished two types - the excitable, and the repressed in whom the emotions are outwardly checked but inwardly disturbed (1937). Maberley (1946) defined instability as 'a weakness or defect in temperament manifested in emotional intolerance of stress and strain and of the demands (or adaptation) by society.' Schonell (1952) offered as a useful working proposition 'The behaviour or condition may be recorded as abnormal when it tends to occur with sufficient frequency to be harmful to the child's personal and/or social development, that is, when the condition becomes sufficiently exaggerated to prevent him from adjusting to his family, school, or general social situation, and thereby using mental energy which interferes with his mental, social or physical development.'

Whilst maladjustment defies adequate objective definition, none would doubt its existence and the application of commonsense and psychology to individual children with their individual problems continued. The concept of maladjustment has evolved, and continues to do so, gradually, a

serious handicap being the lack of quantitative measures of normality or adjustment on the one hand and maladjustment on the other. Both Galton (1880) and Sully (1896) were insistent on the need for large scale surveys as a basis for effective work in child guidance. They contended that more exact information was needed about the average or normal characteristics of children at successive stages in life, about the approximate number of children needing guidance and about changes, mental and educational, occurring in the population from year to year or generation to generation. This was certainly true in the late nineteenth century and is regrettably still true today.

SURVEY OF PREVIOUS WORK

In 1952 Schonell could say - 'so far as I can gather there has not been any extensive or detailed survey of a scientific kind of incidence of maladjustment amongst children at various age levels.' The Underwood Committee which reported in 1955 was unable to obtain any satisfactory estimate of maladjustment in the population, and Blacker (1948) based his estimates largely on existing treatment facilities.

The earliest survey was carried out, largely on Galton's initiative, by a committee of the anthropological section of the British Associations for the Advancement of Science. Their report, published in 1883, was largely confined to physical measurement, but a few years later a scheme which included mental as well as physical measurements was planned under

the guidance of Galton and McDougall. The Child Study Societies at the end of the nineteenth century made some contributions in the study of limited groups and workers in this country and Healy in America were intensively studying groups of juvenile delinquents.

After his appointment to the L.C.C. Burt was able to arrive at an estimate of maladjustement in schoolchildren. In London and Birmingham his surveys suggested that 15 per cent of the child population needed psychological examination. The meticulous studies by Susan Isaacs (1932) between the wars were largely in agreement with this. Using a teacher questionaire technique McFie (1934) found symptoms in 46% of a group of London schoolchildren and regarded this as a 'considerable underestimate'. Cummings (1944) in a study of a selected school population found amotional symptoms in a high proportion of children, with an average of over three symptoms per child. Laycock (1934) Wickam (1933) and C'Arnico (1958) in surveys of schoolchildren, each suggested not only a high incidence of maladjustment but that teachers were likely to give undue emphasis to violations of morality or discipline. It seems likely that reports of incidence in maladjustment based on school populations will give a biased view and are likely to underestimate personal maladjustment of the sort which does not produce conflict with authority.

In recent years the Ministry of Education (1946) has tentatively suggested that there are 1 per cent of maladjusted pupils in the school population between the ages of 5 and 14 years. Whilst the Advisory Council

on Education in Scotland (1952) accepts an incidence of 5% of maladjusted pupils. Blacker (1948) in his "Neurosis and the Mental Health Service" accepted the figure of 1-2 per cent of children in an average school population needing treatment each year. A New Zealand School survey (1949) arrived at the figure of 7.5 % and the surveys carried out on behalf of the Underwood Committee gave estimates of between 5% and 16%

A survey made by a psychiatrist on the staff of the Tavistock Clinic of all 8-year-old boys in an L.C.C. school, judged that 42% were maladjusted. (Underwood Report, 1955). Among adults, Logan and Goldberg (1953) recorded 42 percent of an unselected group of youths registered for National Service at 18 years as maladjusted, and Russell Frazer's (1947) survey among 3,000 factory workers found that 28% of men and 36% of women had suffered some degree of neurotic illness during the six months before examination. The Kent Paediatric Society in "A study in the epidemiology of health" rejected 42% of ten to eleven year old children in Bexley as failing to meet their criteria for physical and mental health. Watts and Watts (1952) in a general practice survey found that 9.4% of psychiatrically ill patients seen in general practice were under the age of fifteen years.

It is evident from the foregoing that there is a wide divergence of opinion on both the nature and the incidence of maladjustment. I think that all would agree, however, that the problem is a real one and that there

is an urgent need for more information particularly in the form of population studies rather than studies of selected groups. In the words of the Underwood report "Yet even if it proves impossible to define maladjustment at all closely, nobody can doubt that maladjustment exists, and it should at leas t be possible to identify it with sufficient precision for our purpose."

The present study is concerned with a representative sample of children, born in Newcastle upon Tyne and living there for at least the first 11 years of their lives. They are selected in that they are representative only of this northern industrial city and in considering any wide implications of this study it is necessary to consider this setting.

Newcastle Upon Tyne

Newcastle has been a centre of population throughout recorded history Its situation as a port, a bridge head on the main route between England and Scotland, and its command of the main east-west communication in Northern England, the Tyne Gap, has been appreciated since pre-roman times.

It has been in succession a Celtic settlement, a Roman bridgehead on Hadrian's Wall, a Saxon village, a Norman Fortress, and a mediaeval town. This continuity of existence and isolation by bad roads and poor communication accounts for the sense of local independence and insularity

attributed to the city and its inhabitants throughout the ages. Even as recently as 1928 Dr. Henry Mess wrote "It will be felt by a stranger who comes to live on Tyneside that it is one of the districts in England with the most marked characteristics and customs, character, manners and speech, strong local pride and strong local conservation, provincial in a true sense with comparative isolation of the area from the rest of England".

It remained a walled city until the latter half of the eighteenth century when a gradual expansion began. Lying in the centre of a coalfield with an adequate waterway and local deposits of iron, lead and copper Newcastle has always been a centre of heavy industry. Iron was smelted locally in Roman times and for centuries Newcastle was the hub of the coal trade. The Boldean Book (the"Domesday Book of Durham") composed in 1183 allowed a smith twelve acres of land for making iron work on condition that he provided his own coal. By 1238 the first collieries were opened in Newcastle and in the following year Henry III presented a charter to the freemen of the town establishing the coal trade. Charles I in 1637 increased his exchequer by granting to Sir Thomas Tempest and partners, at a handsome price, the monopoly of the sale of Newcastle coal for twenty one years (Gibbins, 1890).

In 1642 the city was described in the House of Commons as "the nursery for shipping", and in 1727 Defoe said "they build ships here to perfection."

(Official Handbook, 1916) Glass manufacturing was well established here in the 17th century but like the flourishing chemical manufacturing has since declined.

George Stephenson's experiments with the locomotive engine in 1814 led to the development of the town as an important railway centre. The advent of the railways increased the industrial importance of Newcastle but, according to Clapham (1932), 'Railways had not made Tyneside; it was Tyneside that made them.' Sir Joseph Swann introduced the electrical industries to the area and Newcastle was the first town in this country to have electrical street lighting. The preponderence of heavy industry has had several noteable effects upon the character of the city. During the years of rapid industrial expansion the demand for unskilled labour brought about a rapid increase in population. There was large scale immigration, mainly from neighbouring districts but with some influx of Scots and Irish. Every writer on Newcastle from its earliest historians to its present day politicians has agreed that Newcastle has always been an overcrowded and poorly housed city. The rapid increase in population brought ever increasing pressure on housing and after 1830 regular, parallel rows of terrace houses were built running steeply up from the river, and these provided the 'flats' characteristic of Newcastle's housing in 1947. Dr. Mess (1928) describes these houses thus: "Usually there

A view of Newcastle from it's East End showing in the foreground the parallel rows of terrace houses built as "one up and one down flats" (Photograph by courtesy of Newcastle Chronicle and Journal Ltd.)

is a three roomed dwelling on the ground floor with a four roomed dwelling above. Access to the top flat is by a separate front door or by a steep staircase in the rear. Sometimes there is a grouping of four doors in the front street each giving access to a separate flat, the four flats occupying two separate houses." In evidence before the Royal Commission of 1884-5 the 'town house' of Newcastle was described as "either a large house fallen to tenements or a small house built for tenements each storey being a complete small house of itself." Overcrowding in 1891 was recorded in 35.1% of local dwelling houses (England and Wales 11.2%) and by 1911 had only fallen to 31.6% (England and Wales 8.6%). (Chapham, 1932). The increasing pressure of housing over the years has led to alteration in the composition of the population through the removal of many of those who can afford it to less populous surrounding areas outside the city boundary.

Since 1947 a considerable advance has been made in the housing situation and in the character of the dwellings themselves. Shortage of land within the city has resulted in the policy of slum clearance and multi-storey flat construction. The last 'back-to-back' houses which caused such concern to Dr. Henry Armstrong, the first Medical Officer of Health, in 1873 have at last been demolished.

Owing to the concentration of heavy industry the area suffered

severe depression between the wars. At one time 20,000 men in a total population of under 300,000 were unemployed. (Mess 1928) These black years have had social consequences which are difficult to assess. In 1936 rearmament brought a return to "full employment" but even in October 1938, 292 per 10,000 of the population were in receipt of unemployment assistance benefit (cf. Shoreditch, London's poorest borough, with a rate of 137 per 10,000) (Goodfellow, 1940). However in 1947 Newcastle was a city with a fairly stable population enjoying a period of reasonable prosperity. Of its population of 290,470 in 1947, 20,000 were children under school age and 48,000 school children. The infant mortality rate in 1947 was 44 per 1,000 compared with the last available rate (1958) of 25 per 1,000, but this is the area which in 1936 had an infant mortality rate of 90 per 1,000 (E. & W. 59 per 1,000) a reflection of the grim social conditions of the depression. (Report of M.O.H., 1959).

The Newcastle School of Medicine was established in 1834, its connection with the University of Durham coming in 1852. Physicians of the school showed an early interest in the medical welfare of the city. In 1855, after 500 citizens had died of scarlet fever in a year, a group of physicians presented a 'memorial' to the corporation warning them of the medical consequences liable to result from bad social conditions. The following year a public health committee was

formed with physicians strongly represented. In 1873, despite considerable opposition, the first medical officer of health was appointed (Turner, 1934).

Since that time there has been a close connection between the city public health department and the Medical School of the University. It was against this background that the Thousand Families Survey developed.

The Thousand Families Survey

The survey had its origins in the work of Sir James Spence and F.J.W. Miller in the years before the second world war. (Spence and Miller, 1941). At that time high infantile mortality rates and ignorance of the incidence and causes of infant morbidity were causing concern. In a survey of infant deaths in 1939 one third of all death certificates for children under one year failed to give any adequate account of the cause of death. Experience in a survey of deaths in infancy suggested that a study of illness in the home by intimate and continuous direct observation provided the best hope of reaching an understanding of illness in young children. Further support was provided from records kept by general practitioners which showed that whilst from a quarter to a third of the work of the practitioner was concerned with sick children, only two or three per cent of these children were ever seen in hospital. (Spence et al, 1954) It was evident

that those concerned with the teaching of medical students - and the writing of text books - were seeing but a small fraction of the total illness of childhood, and even that was seen as laboratory specimen isolated from it's intimate environment.

Under such stimulus the concept of a longitudinal morbidity survey was developed. The second world war delayed the natural extension of the early work and the Newcastle 'Thousand Families' Survey did not begin until 1947. Its aim was "to identify the diseases of childhood in a representative sample of families, to trace their origins, and to measure their effects".

The group had to be representative of the population of Newcastle, large enough to demonstrate the range of the commoner illnesses and to justify inference of their incidence, but small enough to permit regular observation in the home with contemporary recording of such observations, and the children had to be followed up as soon as possible after birth. It seemed likely that a group of one thousand children would be optimum and enrolment was to be made at birth. With the prevailing birth rate this meant that one-sixth of the children born in Newcastle during the year must be enrolled. Rather than take every sixth birth throughout the year a method which was administratively impossible it was decided to enrol all infants born in the months of May and June 1947. This did involve the possible introduction of a seasonal bias and meant a heavy initial

load for our health visitors. It had, however, many administrative advantages and the early visiting could be done in reasonably good weather.

Much initial preparation was done in the six months before the survey began. Meetings were held with the midwives, designing and carrying out a pilot survey with the form to be used during the first two weeks of the child's life. The plans were discussed at meetings with the maternity and child welfare staffs, including all the city health visitors who were asked for their help and support. The maternity hospitals and nursing homes in the city were visited and all agreed to help. The medical staff of the children's hospitals agreed to co-operate by sending a copy of the notes of any child admitted orseen in out-patients, and to permit a member of the team to see the child whilst in hospital. Contact was established with the family doctors, whose support and acquiescence was essential to the whole project, through a meeting of the local branch of the British Medical Association, a circular letter to all family doctors in the city, and personal visits to family doctors by members of the team.

The team consisted of three medical members from the University Department of Child Health and the Medical Officer of Health. All had other clinical and teaching committments, and it was only towards the end of the first year that they were joined by a full time medical worker.

The City Public Health Department provided secretarial staff and five specially selected and trained health visitors.

Children were enlisted into the sample from notifications of birth in the city health department from May 1st to June 30th, 1947. The midwife caring for the infant, in home or private hospital, or the paediatrician in the public hospital kept a record of the progress in the first 14 days and this record sheet with antenatal charts when available began the dossier on each child. Contact with the families was established by the special health visitors who made their first visit as soon as possible after the mother had been discharged from hospital or the care of her midwife. Visits were made to the home and at the first visit a frank discussion of the aims of the investigation took place and the parents were asked for their co-operation. Subsequent visits were made at intervals of six weeks during the first year, every eight weeks during the second to fifth years, every three to four months during the sixth and seventh years, and thereafter annually. In addition to these routine visits many families had more frequent visits from their health visitors, and families were visited less frequently by medical members of the team - often when the health visitor wished to have an independent opinion of some recent event in the household.

The parents were encouraged to report by post card or telephone when there was an illness or upset in the household and additional visits

were arranged in response to these calls. Many family doctors passed on information by letter or telephone, and all hospital visits and admissions were notified. In later years the schools provided notification of school absence and access to the children. In this way an excellent relationship was built up between the families and the survey, particularly of course with their 'own' health visitor. The small number of withdrawals from the survey provides an indication of this relationship and is a tribute to the remarkable skill of the health visitors. This is even more remarkable when one remembers that throughout the investigation it has been emphasised that the team were observers and in no way could they interfere in the medical management of these children.

Between May 1st and June 30th 1947 a total of 1142 infants from 1132 families were born to mothers normally resident within the city of Newcastle. These were all enrolled in the survey, and because of the legal seal used to identify communications regarding them, they were soon known as 'Red Spot' children. This group reflected the social pattern of the city and was comparable in all available statistics with the city population at that time.

During the first year 44 infants died, 127 removed from the city and 4 children left the survey because their parents withdrew co-operation. Three children died in the second year, two in the third year and none has died since. By the beginning of the tenth year eight other children had

been withdrawn either at their parents request or due to lack of co-operation, and removals from the city had reduced the group to 791 children.

In the course of the survey a large dossier had been built up on each child and covered a wide range of information. As relationships with the parents became better established so did the range and volume of data increase. Whilst the role of our visitors as observers had been emphsised throughout the study, parents have inevitably discussed their problems in all fields of child rearing.

I joined the survey as full time medical office when these children were in their eighth year and was soon concerned with sharing routine and request visiting, preparing data for analysis and carrying out routine physical examinations.

By this time several groups had emerged such as children with chronic respiratory symptoms, physical handicaps of other kinds, children who had experienced convulsions, or behaviour problems. Any or all of these groups would be worthy of further study but I found myself increasingly interested in the maladjusted or behaviour problem group.

Although the survey was primarily a study of infective illness, by the age of 5 years the case records contained many instances of problems of behaviour, and at this time the first specific enquiry was made.

Health visitors were asked at five years to keep a record of these

children who appeared to have a disturbance of behaviour beyond the normal range on a basis of complaints from the mother and their own observations. Further specific lists were made at seven years and at ten years. It should be emphasised that though specific listing was done at these ages the problems came to notice gradually and as they occurred over the years.

It seemed that here might be an opportunity to provide an estimate of the incidence of maladjustment in a true sample of the population and to indicate some of its social and other associations. With this in view I examined the haalth visitors "behaviour problem" lists. Taking as my criteria:substantial episode of disturbed behaviour based on repeated complaints from the mother or recorded observations by members of the team, I prepared a comprehensive list. Of the 791 children still in the investigation at 10 years, 154 children were listed as having had a substantial episode of disturbed behaviour. The size of the maladjusted group (19.4 per cent of the total) evidently justified a more detailed enquiry.

THE PRESENT STUDY

Having isolated an arbitrary 'maladjusted' group within the survey population, two questions were outstanding - did this group in fact represent a valid division, were these children really maladjusted as compared to their fellows: and did this represent a true population incidence of maladjustment?

Arising from the answers to these questions it is also desirable to know what factors, social and economic, are associated with maladjustment and in what way does maladjustment present.

The approach adopted to these problems was to make a further detailed study of the maladjusted group and to compare them with a control group taken from the whole survey population.

The control group was made up by taking every sixth child on our records. This group consisted of 131 children but of these 22 were common to both the maladjusted and the control group. Thus, in the study there were 132 maladjusted, 109 controls, and an overlap group (maladjusted/controls) of 22.

A standardised interview seemed to be the most satisfactory method of covering such a wide field as behaviour and social background, and the pro-forma whown in Appendix 1 was constructed after a small pilot survey had been carried out. The method of recording variations in behaviour was the main problem here. A variety of methods was considered.

The symptoms classification given in Appendix B of the Underwood Report (1955) and similar classifications in common use in Child Guidance Clinics appeared inadequate for work of this nature. They lack flexibility and give little indication of the range of behaviour in a particular case. The same objections applied to a simple check list based on

symptoms known to occur in the maladjusted group, which had the further disadvantage of implying acceptance of the group as an abnormal one without further objective evidence.

Ackerson (1931 and 1942) reviewed the case records of 2,853 white boys and 1,739 white girls referred to the Illinois Institute for Juvenile Research for investigation and treatment. From these records he constructed a massive list of symptoms, or "notations", and calculated the incidence and interrelations of each symptom. The main disadvantages of this scheme were the absence of precise definitions for each symptom and the probability of overlap between many of the categories.

Many of the other available methods of classifying behaviour depend upon the acceptance of particular psychological concepts. Holzmn (1953) relates symptoms to primary emotions and divides behaviour into direct, indirect, and compound symptoms. Lewis (1954) adopts a modification of the classification introduced by Hewitt and Jenkins (1946). The factor of neuroticism described by Eysenck and his co-workers (1952) involves not only acceptance of their concepts but the administration of individual objective tests.

McFarlane, Allen, and Honzik (1954) in the California Guidance Study used a set of rating sclaes for behaviour items. Each item was ranged over a five point scale from one extreme of behaviour through various grades to the other extreme and arbitrary divisions were made

between 'problem' and 'normal' behaviour. This scheme had the advantage of covering wide ranges of behaviour without predetermined grouping of symptoms.

The method finally selected was a set of rating scales based on the scheme used by McFarlane et al and a series of questions on the child's background and experience.

A school report form, including trait ratings (Valentine, 1940), was also constructed and sent out for completion by the child's primary school teacher. (Appendix 2)

It had been my original intention to interview both parents, but the pilot survey rapidly demonstrated that this was impracticable and eventually I decided to interview the mother only in her own home. Of the nine children whose mother had died, in one case the father was interviewed, in three the stepmother, and in five a grandmother who had assumed responsibility for the child. One illegitimate child had been deserted by his mother and was in the care of his grandmother who was interviewed. In one case the mother was unable or unwilling to find the time to see me and the father was interviewed.

The interview took place by appointment in the mother's own home. The average duration was one and a quarter hours but this varied from 45 minutes to 3 hours. Each questionnaire was completed in a single session. Three mothers asked to be interviewed in the clinic but in each case the

home was already known to me.

Appointments were made by sending a postcard to the mother stating that I would call on them at a particular time unless I heard from them that this was inconvenient, this being the standard method used by our health visitors since the children started school. On visiting the house, if the mother was in, it was explained that we were anxious to ask a number of questions about the behaviour, background and development of 'Red Spot' children in order to help us to understand and compare children who had developed 'nervous' troubles. I explained that this would take about an hour and arranged to call again if time could not be found on that occasion.

When the postcard was not acknowledged and the mother was not at home, an explanatory letter was sent asking for an appointment (Appendix 3A) If this was ignored a further letter (Appendix 3B) was sent again stating a time at which I would call. None of the mothers actually refused to be interviewed but six of the maladjusted group and four of the control group were not interviewed despite repeated visits.

Three hundred and seventy eight visits were made in order to complete the 253 questionnaires. The visits were made over a ten month period between March 1958 and January 1959.

The visiting was done in random order largely on the basis of geographical convenience. Pro-formas were marked with the name and address of the child and a chronological list of siblings. The latter

was checked at each interview and was used largely to provide an initial talking point for the interview. No indication of the group to which the child belonged was given on the pro forma.

The interview began with the brief explanation of its purpose as already given, and it was emphasised that the material would be treated as highly confidential. At this stage I asked the mother if she would mind me making notes on the pro-forma as we talked. I apologised for the essentially personal nature of many of the questions I would have to ask and explained that these were necessary if we were to make complete comparisons with 'nervous' children. If other adults or children were present I asked the mother, in view of the intimate nature of the discussions, if she would prefer me to return when she could be interviewed alone. Thirty four mothers asked for the interview to continue in the presence of other adults, usually female relatives, and seventeen where there were children present - usually pre-school children.

So far as I could judge 241 of the mothers interviewed co-operated wholeheartedly, the remaining twelve, though agreeing to and completing the interview, had a guarded or suspicious attitude.

On the completion of the interview the form was checked against existing records and any additional data noted. The child was then assessed by me as severely or persistently maladjusted, moderately disturbed or within the normal range. Maladjustment was taken to mean the

development of behaviour or habits severe enough to cause disturbance in the family or at school

The data was then transcribed onto analysis sheets together with the information obtained from the school report forms, and the grading examination results for each child. The latter consisted of three scores, the mean of two verbal intelligence tests, an arithmetic quotient and an English quotient. (for coding list see Appendix 3).

Hollerith cards were punched for each child and the data sorted, using a counter-sorter.

The data will be presented in two main sections. In the first each symptom range will be described, the differences between the study groups considered, and an attempt made to confirm the validity of the maladjusted group. The second section will deal with the background and experience of the children and possible aetiological factors will be discussed. Finally the study will be reviewed and the general conclusions discussed.

PART TWO

THE CHILDREN AND THEIR SYMPTOMS.

This section will be devoted to a consideration of the symptoms recorded in this study, each symptom group or behaviour category being considered separately, largely in order of their appearance in the interview pro-forma (Appendix 1).

For each symptom range, the five point rating scale, where applicable, and the actual total numbers in each category for each of the three groups in the study, will be shown. Each behaviour category is graded and arbitory out off points determined; the 'problem' grades are indicated by the use of brackets and may involve one or both ends of the scale. Children who have previously exhibited the symptom but are, on present behaviour, included in a normal grade are also recorded under 'Previous Symptoms'. For purposes of statistical comparison all 'problem' grades are compared with all non-problem or normal grades and a Chi squared test applied to determine the significance of differences between the maladjusted and control groups. Unless otherwise stated Chi squared is to one degree of freedom and a level of $P<0.05$ is regarded as statistically significant.

Intersymptom correlations have been calculated for thirty of the symptoms in the maladjusted group (see correlation matrix Appendix 4) and significant correlations are quoted where available. With a group of this size (N=126) a product moment correlation of over 0.170 is accepted as significant.

The sex distributions for each symptom are expressed as the percentage of children of each sex, manifesting problem behaviour and are given for the maladjusted and control groups. A population estimate is also given, calculated from the combined control plus maladjusted control groups. The latter figures are thus derived from the one in six sample of the "Thousand Families Survey" population. Differences in sex distribution have been calculated from the proportions of each sex manifesting the symptom and a difference exceeding twice the standard error of the distribution has been accepted as significant.

Case histories have been included in this section rather than in an appendix in order to provide an indication of the use of the rating scales (each case quoted being in the most severe category of the symptom under consideration) and to aid in the evaluation of the significance of alleged maladjustment in this study. Each case history follows a similar pattern comprising a description of the manifestions of the symptom under consideration, a general account of the child's behaviour development, a synopsis of severe illness and separation experience and a brief account of his family background.

1. DREAMS

(1) Disturbing dreams almost every night or nightmares at least once a month.

(2) Disturbing dreams at least once a month and/or nightmares once every two months.

(3) Pleasant dreams at least twice a week and disturbing dreams twice a month or two or more nightmares per year. Child prefers not to dream.

4 Occasional pleasant dreams, infrequent disturbing dreams and/or usually talks in sleep.

5 No dreams.

6 Previous symptoms.

TOTAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED BOYS	MALADJUSTED GIRLS	CONTROL BOYS	CONTROL GIRLS	MAL./CONTROL BOYS	MAL./CONTROL GIRLS
(1)	6	1	0	1	0	1
(2)	2	1	0	3	0	0
(3)	4	3	1	2	1	0
4	29	22	23	17	7	3
5	35	23	35	23	7	3
6	12	6	2	0	1	0

Maladjusted as Controls
$X^2 = 2.68$ (
Not significant

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	15.8	10	13.5
Control group	1.7	13	6.7
Population estimate	2.7	13.2	7.7

Difference = 2.28 times standard error

2. SLEEPWALKING

	BOYS	GIRLS	TOTAL
Maladjusted group	8 (10.5%)	5 (10%)	13 (10.3%)
Control group	3 (5.1%)	5 (10.7%)	8 (7.6%)
Mal./Control	0	1	1
Population Estimate	4.1% boys	11.3% girls	7.1% of total

DREAMS

According to Kanner (1957) nightmares or night-terrors "are more or less drastic indications that something is wrong with the child and that it is his personality that is in need of investigation and adjustment". Shirley (1948) is more cautious but believes that frequent episodes of this nature are usually evidence of personality difficulties. Ackerson (1931) in his monumental studies from the Illinois Institute of Juvenile Research found an incidence of 2 - 3% of nightmares or night terrors in a group of over 3,000 problem children referred to the Institute. Douglas and Blomfield (1958) reported "nightmares" in 30% of their group of under fives but this appears to have included any incident of disturbed sleep.

In this study symptoms were found in 17 (13.5%) of the maladjusted group and 7 (6.7%) of the controls but this difference is not statistically significant (X^2=2.68). Fifteen point eight per cent of boys and 10% of girls in the maladjusted group and 1.7% of boys and 13% or girls in the control group were included in problem categories. The population estimate is 2.7% for boys and 13.2% for girls and here the difference is statistically significant.

Sleepwalking at any time was recorded in 13 of the maladjusted group and 8 of the control group (X^2=0.23). Whilst the sex incidence showed little difference in the maladjusted group, this symptom was more common

among girls in the dontrol group, though not significantly so.

Illustrative Case:-

Brian began to have nightmares at the age of seven years and for over a year he had this disturbance every night. Commonly he would dream that he was falling and wake in a state of terror. After a year of this his family doctor prescribed regular phenobarbitone and since then the nightmares have become less frequent, occurring about twice a month but he now gets "sleep paralysis". His mother, who herself suffered from this as a child described it as a state of sudden waking, inability to make any movement and a feeling of real terror; after a variable period movement gradually returns and the boy is able to get up or go back to sleep.

On six occasions in the past few years he has been found sleep-walking; it has always been possible to get him back to bed without waking and on the following morning he has had no recollection of the incident. Apart from these disturbances he has always been restless at night, frequently tossing and turning and always kicking off his bedclothes so that his brother, four years younger, has never been able to share a bed with him. Despite his phenobarbitone he usually has difficulty in getting off to sleep and often lies reading 'for hours' before going to sleep.

At two and a half years he began to wander away from home initially straying to nearby shopping centres or parks and being brought home by neighbours but his range has gradually increased and he now explores the surrounding countryside. On at least two occasions he has been brought home by the police but he usually manages to find his own way home, often late at night. Various forms of punishment and bribery have been tried to curb his wanderlust but his wandering continues daily.

Since the age of five years he has had a series of tics including blinking, mouth twitching, sniffing, head jerking and throat clearing, with at least one or other of these always active. At five and a half years he had a three month period during which he masturbated every night and was very shamefaced about it. Between the ages of five to seven years he wet the bed every night but now has spells of several months without incident. Now and again he wets his trousers and since the age of seven years he has frequently soiled his underclothes.

He is a tense, restless boy who finds it difficult to sit still, is careless with clothes and toys and 'no toy lasts longer than five minutes'. Although an independent boy who never shows affection, he prefers to have help with routine tasks. An argumentative child who 'always knows best', he will fight with anyone at the slightest provocation. Whilst he is foolhardy and takes foolish risks, he is afraid of the dark

when at home and refuses to cross a bridge on foot. With strangers he is very shy and for this reason will not go shopping and shows a marked reluctance to visit other peoples' houses.

At home he is attention seeking, jealous of his younger brother, easily upset and bad tempered, frequently bursting into temper tantrums. His mood is unpredictable and at times he becomes very depressed. Despite erratic behaviour in school he is now holding his own at a selective (Commercial) School.

He has twice been in hospital, at seven and half years for three days when his tonsils and adenoids were removed and at nine and a half years for two weeks with dysentry. At the age of six years he was separated from his mother for one month whilst she was in hospital and his father has spent a month at a T.A. Camp each year since he was born.

His father, a postman driver, is a dour phlegmatic man, an ex-P.O.W. and inclined to be moody. He is said to be unable to show affection and had a very unhappy childhood, eventually running away to join the army at the age of sixteen.

The boy's mother was illegitimate and when aged four years her mother married a strict rigid man who did not get on well with his step-daughter. She had always been troubled with 'nerves' and had many neurotic traits in childhood. After a good grammar school education she took up inspection work in a factory but feels that she 'hasn't made anything' of her life. At the age of nineteen years she traced her natural

father, a highly intelligent master joiner who has been in and out of mental hospital all his life. She visits this man from time to time and this has resulted in estrangement from her own mother.

3. NOCTURNAL RESTLESSNESS

(1) Restless almost every night, much tossing and turning. Bedclothes usually on the floor. May fall out of bed or move from own to parents bed. Wakes frequently at slight noises.

(2) Restless 2 - 4 nights per week.

3 Occasional restlessness.

4 Restless once or twice a month.

5 Unusually sound sleeper

6 Previous symptoms

TOTAL NUMBERS IN EACH GROUP

	MALADJUSTED		CONTROL		MAL/CONTROL	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	2	0	0	0	1
(2)	14	7	3	5	3	1
3	9	6	4	8	1	1
4	9	7	9	2	2	2
5	41	28	43	30	9	2
6	7	2	0	0	0	0

Maladjusted as Controls
$X^2 = 6.58$ P < 0.02

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	22.4	18.0	20.6
Control group	5.1	10.9	7.6
Population estimate	8.1	13.2	10.2

4. DIFFICULTY IN RISING

	BOYS	GIRLS	TOTAL
Maladjusted group	10 (13.2%)	5 (10%)	15 (11.9%)
Control group	8 (13.6%)	9 (19.6%)	17 (16.2%)
Mal./control group	1	0	1
Population estimate	12.2% boys	17% girls	14.2% of total

5. INSOMNIA

	BOYS	GIRLS	TOTAL
Maladjusted group	15 (19.7%)	14 (28%)	29 (23%)
Control group	7 (11.9%)	6 (13%)	13 (12.4%)
Mal./control group	4	1	5
Population estimate	14.9% boys	13.2% girls	14.2% total.

NOCTURNAL RESTLESSNESS

Shirley (1948) found nocturnal restlessness a common complaint which occurred in about 5% of his clinic group, whilst Ackerson (1931) recorded the complaint in 12-14% of his group and found significant correlations with food fads, general nervousness, durnal restlessness, nail biting, nocturnal enuresis and irritability. Both Shirley and Kanner (1957) emphasise the need to exclude physical causes of discomfort at night and in the present study, cases were included in the symptom category only when no physical cause was evident.

The difference in absolute numbers between the maladjusted and control groups is significant ($P < 0.02$) amongst maladjusted males and normal females but the sex differences within the groups are not statistically significant.

Intersymptom correlations were significant for emotional dependence (0.232), sadness or depression (0.212), lying (0.209), temper (0.196) and instability of mood (0.178). Despite a clinical impression of an association with durnal restlessness, the correlation coefficient in this case was 0.119 which is not significant.

A complaint of insomnia was recorded in 29 (25%) of the maladjusted group and 13 (12.4%) of the controls, a difference which is not statistically significant. Ackerson (1931) recorded the symptom in only 5-6% of his group and the high incidence in the present study may be due to the

inclusion of children in whom the complaint should properly be regarded as a continuation of reluctance to go to bed.

Fifteen (11.9%) children in the maladjusted group and 17 (16.2%) of the control group were difficult to get out of bed in the morning but this was not associated with a proneness to enuresis.

Illustrative Case:-

Although never troubled with frank nightmares, Freddy has always been a disturbed sleeper, tossing and turning throughout the night, every night. He only wakens up during the night on those frequent occasions when he falls out of bed but he does not always waken then. His parents replace his bedclothes several times in the night as they are habitually on the floor.

As long as his mother can remember, he has chewed his nails and since the age of 5 years he has had a marked tic involving his face and shoulders which varies in intensity but is always present to some degree. Whenever he is in trouble, he lies systematically to avoid reprimand and he is inclined to be destructive both with clothes and toys, usually pulling the latter apart 'out of curiosity' and having no real sense of value of the property. Although he never has tantrums, his mother describes his temper as vicious and he is frequently involved in fights both at play and in school. She regards him as never having been able to show any affection and even as a baby he resented being fussed or nursed.

At home he is regarded as restless and overactive whilst at school, which he dislikes he is considered fidgetty and inattentive, His parents feel that he is 'picked on' at school by both children and staff and attribute his present problems to this. He is regarded as dull average at school being good at reading and spelling but poor at arithmetic.

He has never been separated from either parent though his mother began in full time work when he was aged five years; nor has he has any serious illness.

His mother is a rather overanxious but concientious and capable housewife and mother who claims to suffer from 'nervous debility'. There are two other children in the family, both girls, one older and the other eight years younger than Freddy.

Father is a hardworking industrious man who works long hours on a distant open cast coal site as a tractor driver, and consequently often never sees the children for weeks on end. In the past few months he has been in poor health due to a recurrent nephritis and may soon be forced to give up his work. He is perplexed by Freddies behaviour and feels that he needs some kind of treatment but in general leaves the boy's management to the mother.

6. NOCTURNAL ENURESIS.

(1) Nocturnal enuresis - two or more nights per week.

(2) Two to four nights per month with real loss of sphincter control or bed damp at least twice per week.

(3) Wet bed once per month or bed frequently damp but less than twice per week.

(4) Previously wet regularly but only one wet bed in past six months.

5 No enuresis.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CON.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	13	6	5	2	0	1
(2)	2	1	0	1	0	0
(3)	2	2	1	0	0	0
(4)	4	3	3	0	0	1
5	55	38	50	43	15	5
6	17	11	6	1	4	2

Maladjusted as Controls

$X^2 = 7.08$ $P < 0.01$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	27.6	24.0	26.2
Control group	15.3	6.5	11.4
Population estimate	12.2	7.5	11.0

NOCTURNAL ENURESIS

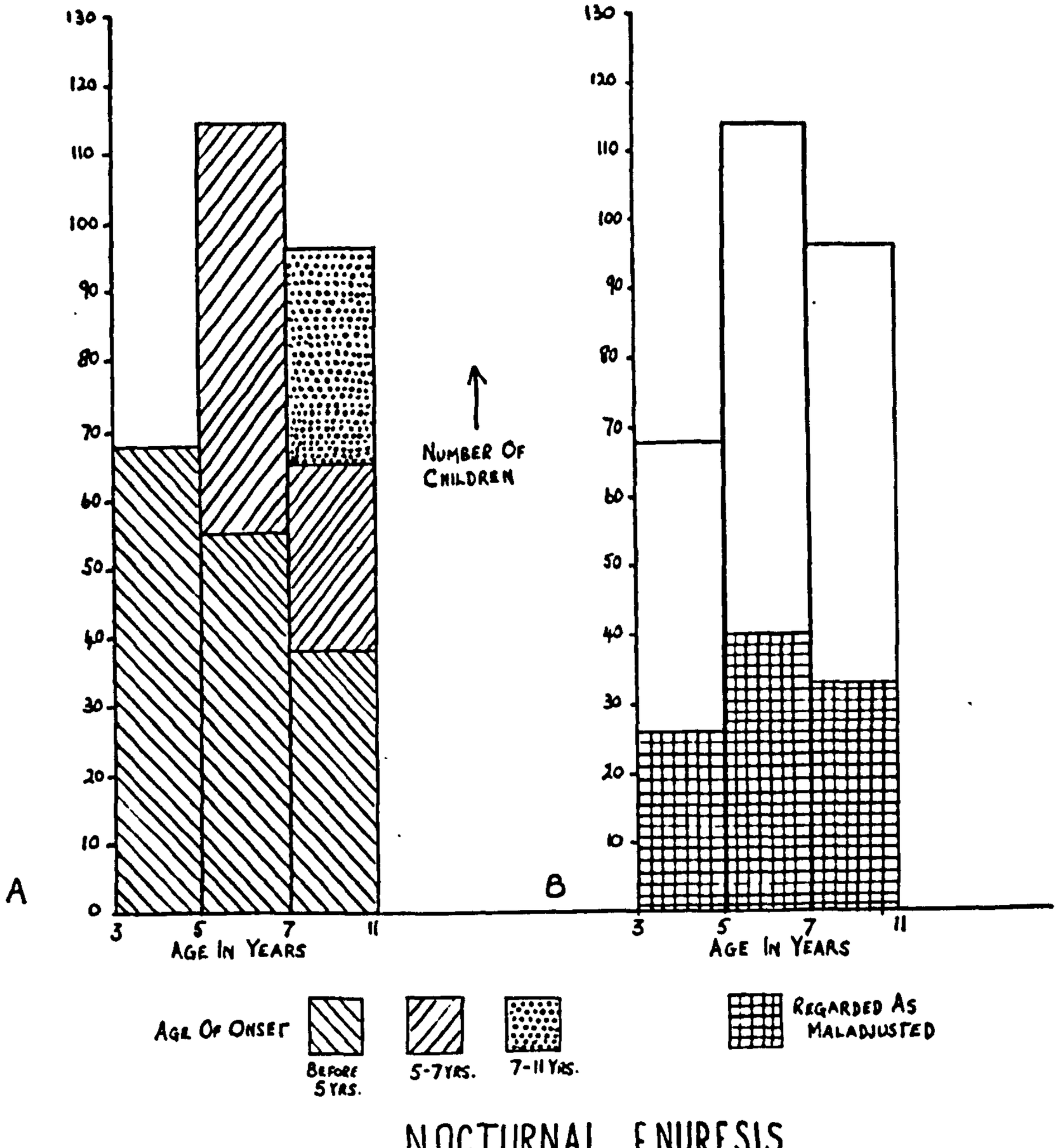
There is little general agreement in the vast literature of this subject though nocturnal enuresis is generally accepted as a common complaint and usually considered to be more common amongst boys. Thursfield (1923) however, found the symptom more common amongst girls.

Douglas & Blomfield (1958) recorded nocturnal enuresis in 12% of their group at age of 4½ years. Shirley (1948) found 13.4% enuretics in his group and Kanner reports enuresis in 26% of children seen at the Psychiatric Service of John Hopkins (though 7% of these were wet by day only).

Since nocturnal enuresis has been recorded fairly consistently throughout the duration of the Thousand Family Investigation, it would seem worthwhile to examine here the figures for the entire investigation group.

Amongst the 791 children still under observation at their tenth birthday 68 (8.6%) were anuretic between the ages of 3 years and 5 years. Of these 68 children, 25 are included as maladjusted in the present study and 13 of them, including 5 of the maladjusted were dry between the ages of 5 - 7 years.

During the period 5–7 years, 113 children (14.3%) were enuretic



NOCTURNAL ENURESIS

Showing total number of children (from Survey Group of 791) in each age period

A) with age of onset B) showing number considered maladjusted.

and these include 40 of the present maladjusted group. Thirty five of these 113 children were enuretic before the age of 5 years, thus the group includes 58 'secondary enuretics', 20 of whom are members of the maladjusted group.

For the period 7-11 years, the prevalance was 12.2%, 96 children, of whom 33 are found int the maladjusted group. The children in this age group fall into four groups; 35 who were enuretic during each age period considered (including 12 maladjusted), 27 who were wet between 5-7 years and 7-11 years(including 10 maladjusted), 31 who were wet only during the period 7-11 years (including 9 maladjusted) and 3 children who were wet before 5 years and after 7 years but not between 5-7 years (two of these were considered maladjusted).

To summarise, primary nocturnal anuresis was seen in 68 children (8.6% of total), in 10 children it did not continue after the 5th birthday, 20 of the children ceased to wet the bed before age 7 years and 38 children were still wet during the 7-11 year period. During the 5-7 year period 'secondary enuresis' was seen in 58 children, 31 of whom were not wet after the 7th birthday though the symptoms continued in the remainder. Of the 96 children with the symptom in the 7-11 year period, 38 were of the continuous variety, primary enuresis, 27 were secondary enuretics continuing from the five to seven year period, and in the remaining thirty one children the symptom of secondary

nocturnal enuresis had developed for the first time.

The symptom occurred somewhat more commonly in boys; 41 (60%) of the primary enuretics were boys, of 113 children wet between 5–7 years 61 (54%) were boys and the percentage was the same between 7–10 years, 52 boys in a total of 96 children. These differences are not, however, statistically significant.

Although the proportion of maladjusted children remains remarkably constant in each group of enuretics considered and in spite of the fact that enuresis was never the sole reason for inclusion in the maladjusted group, a comparison between the maladjusted and control groups in respect of nocturnal enuresis demonstrates a statistically significant difference. Thirty three children in the maladjusted group were enuretic as compared to 12 in the control group, Chi squared for the difference is 7.08 with $P < 0.01$.

Inter-symptom correlations were 0.210 for durnal over-activity, 0.250 for emotional dependence and 0.213 with durnal envesis (7 of the 33 maladjusted enuretics were also wet by day).

These figures may be of some value in estimating the accuracy of ascertainment of other symptoms, as they are derived independently of the present study. Thus, the total number of children enuretic at any age is 157, the maladjusted plus maladjusted/control group contains 24 children enuretics at any age, which would lead to an expection of 144 enuretics – a fair measure of agreement.

<u>Illustrative Case:-</u> Norman and his parents lived with his paternal

grandparents until he was two years old. The dominating grand-mother monopolised the care of the infant, relegating his mother, much to her resentment to household tasks. Toilet training was started at the age of five months, and at first he strenuously resisted the potty, but was forced to "sit" at the appointed time. By the age of 10 months he seemed to have accepted a toilet routine and at eighteen months, adequate bowel control was established, but he continued to wet himself intermittently during the day until the age of 6 years. Nocturnal enuresis occurred almost nightly until the age of $8\frac{1}{2}$ years when it ceased dramatically a few days after commencing treatment with epanutin and phenobarbitone for epilepsy.

From the age of $2\frac{1}{2}$ years this boy often woke in the night screaming with terror. When he was aged 3 years 11 months he had a short period of constipation which his mother decided to treat with glycerine suppository; the boy vigorously opposed her attempts to insert the suppository and during the ensuing struggle had a major confulsion, followed within half an hour by two further major attacks. His doctor was called but apart from short term sedation, no treatment was given. At the age of 4 years and 11 months, he developed a high fever during the prodromal stage of measles and had another major seizure; again no treatment was given. In the meantime his nocturnal attacks of terror

continued, becoming gradually more frequent. At times he had nightmares in which he awoke trembling with fear and complaining of "funny feelings all over" whilst at other times he had night terrors in which he screamed about funny shapes and shuuted "keep them off" but after a few minutes lapsed into deep sleep and was unable to recall the incident next day.

By the age of 7½ years, he was having attacks every night and insidiously, they began to occur during the day. He would not lose consciousness during these diurnal attacks but would crouch on the floor crying and complaining that his head felt enormous whilst the room and people around him appeared smaller. He also complained that any movement of his hand or arm appeared accelerated and when he tried to lift his arm slowly, it appeared to sweep rapidly upwards.

After six months of these diurnal attacks his parents sought medical advice and a diagnosis of epilepsy was confirmed by the E.E.G. finding of almost continuous regular delta activity arising mainly from the R. porieto-occipital region. Treatment with epanutin and phenobarbitone brought a prompt cessation of the nocturnal and diurnal disturbances and of his enuresis, although all these symptoms recurred for a few days during an acute febrile illness a year later.

In other respects Norman has always been a timid boy who needs a good deal of support from adults in most of his activities and tendsto

seek the company of younger children. At the age of 9 years, just a few months after his dramatic "cure" he had a period of acute anxiety about his school work and began to soil his trousers. Since then he has continued to soil his trousers every few days and apart from chiding from his parent s he has not had any treatment for this but does not appear to be constipated.

Norman has never been in hospital and his only separation from mother was at the age of $4\frac{1}{2}$ years when his sister was born, mother being in hospital for 18 days. He has had no serious illnesses and there was no history of birth injury.

As already mentioned, until the boy was 2 years old the family lived with his paternal grandparents. The grandmother is a very possessive woman who immediately took charge of the infant to such an extent that his mother felt she was never allowed to do anything for him and was "deprived of the pleasure of her own infant". Mother is a pleasant woman of good average intelligence, fond of her home and children and copes well with her responsibilities.

Fa ther is a rather fussy over-anxious man who is good with the children but has never had a particularly close relationship with Norman. He has worked regularly as a Lino-Type operator, often working long hours and is in good health apart from psoriasis.

7. DIURNAL ENURESIS

(1) Diurnal enuresis on two or more days per week.

(2) Two to four days per month with real loss of sphincter control or damp two days per week.

(3) Wet one day per month or frequently damp but less than two days per week.

(4) One episode of daytime wetting in past six months but previously more frequent episodes.

5 No diurnal enuresis.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CON.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	4	3	0	0	0	2
(2)	0	0	1	0	0	0
(3)	0	0	0	0	0	0
(4)	3	3	0	1	0	0
5	68	44	58	45	15	5
6	7	5	0	1	1	0

Figures too small for Chi-squared test

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	9.2	12.0	10.3
Control group	1.7	2.2	1.9
Population estimate	1.4	5.7	3.2

DIURNAL ENURESIS

American writers appear to equate diurnal and nocturnal enuresis, Shirley (1949) regarding diurnal enuresis without bed wetting as relatively uncommon but claiming that one third of enuretics are wet by day and night. Neither is any distinction made by Ackerson (1931) who found a history of enuresis in his group in 28% of the boys and 22% of girls but does not distinguish between nocturnal and diurnal enuresis. Kanner (1957) found that 30% of his enuretics were wet both day and night and 7% were diurnal enuretics only.

In the present study 13 of the maladjusted group and two of the controls were wet by day, but of those now dry 11 of the maladjusted and only one of the controls had a previous history of diurnal enuresis. If those with past and present symptoms are combined a Chi-squared of 14.9 is obtained with $P < 0.001$. Seven of the 13 children in the maladjusted group and one of the controls are also wet at night.

Diurnal enuresis was present in 9.2% of boys and 12% of girls in the maladjusted group whilst the 'population estimate' is 1.4% in boys and 5.7% in girls. Thus in contradistinction to the nocturnal enuresis this symptom is commoner in girls though the difference is not statistically significant.

Intersymptom correlations were 0.334 with faecal soiling, 0.213 with

nocturnal enuresis, 0.198 with disturbance of appetite, 0.197 with lying, 0.194 with physical timidity and 0.175 with irritability.

Illustrative Case:-

Ethel's toilet training started early and was apparently uneventful, by the age of a year she was clean and dry. At the age of 3 years she began wetting her bed and, apart from a few dry nights at irregular intervals she has been wet ever since. She remained dry during the day until shortly after starting school since when she has wet her pants several times a day. Repeated physical examinations and urine analysis have been negative.

Ethel is an extremely shy, timid child with 'no push', though normally obedient she occasionally flares up into a temper tantrum. Since infancy she has had a variable appetite and numerous food fads including an aversion for most vegetables. Whilst she used to take great ware of her toys and clothes she has, in the past year become rather careless and no longer takes any pride in her appearance. She has always tended to be unusually generous in giving away her toys and her mother considers that she has no sense of value for property or money. Her nails have 'never been cut' as she is always biting them and she lies readily to avoid trouble. Although she used to cling to and appear very dependent upon her grandmother, she has been fairly independent since the latter's death a year ago.

She has not had any serious illness but at the age of 1 year four months fell from a chair in what has been regarded from contemporary description as a major convulsion. Her mother has worked intermittently since the child was six weeks old leaving her in the care of her grandmother and when Ethel was two years old mother left the household.

Ethel was an unwanted child. Her mother had been enjoying an active social life whilst her husband was in the Air Force and although he accepted paternity of the child, he had grounds for doubt. From the beginning, the management of the child was left to the maternal grandmother with whom they were living. Mother soon obtained a full time job and resumed her social activities, was sexually promiscuous and quite irresponsible financially.

For the first few months the baby slept in her room at night but she was so ill tempered with the infant, smacking her and throwing her across the bed if she cried, that grandmother took the baby into her own room.

The somewhat tenuous marriage continued, though the parents often did not see or write to each other for periods of up to a year. Ethel was five years old when her father was demobilised. He obtained a job and tried to settle down to family life, much to the disgust of his wife who expected to continue her old associations and demanded more money

than he could supply. After three months, he left the household, still at grandmothers and a few months later divorced his wife. He has since sent Ethel an occasional present but did not apply for her custody nor has he attempted to see her.

Shortly after the divorce, mother, who had stayed there only intermittently since Ethel was aged 2 years, finally left the household and established a home of her own. She left Ethel with grandmother and made no attempt to keep in touch with the child.

Three years ago this mother re-married and now has another daughter just over 2 years old. Ethel continued to live with grandmother until her death a year ago when her mother, for the first time, relunctnatly assumed responsibility for her care.

8. ENCOPRESIS

(1) Faecal soiling with real loss of sphincter control on two or more days per week.

(2) Real sphincter loss two or more days per month or staining twice per week.

(3) One episode per month or frequently staining but less than twice per week.

(4) One episode in past six months.

5 No soiling.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CON.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	6	1	0	0	0	0
(2)	2	0	0	0	0	0
(3)	0	0	1	0	0	0
(4)	3	0	0	0	3	0
5	65	49	58	46	12	7
6	8	5	0	0	4	1

Maladjusted as Controls
$K^2 = 18.6$
$P < 0.001$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	14.5	2.0	9.5
Control group	1.7	NIL	1.0
Population Estimate	5.4	NIL	3.2

Difference= 2.34 X Standard error

(Difference = 1.71 X Standard error)

FAECAL SOILING

Shirley (1938) found amongst children referred to the Harriet Lane Psychiatric Service in Baltimore over a seven year period an incidence of 2.91% of all cases but a later study from the same centre by McTaggart and Scott (1959) gave an incidence of 6% of all cases seen. Ackerson (1931) reported faecal incontinence in 4% of boys and 3% of girls whilst Anthony (1957) in selected research material found a six to one excess of boys over girls showing this symptom.

In this study, twelve of the maladjusted group (9.5%) and only one of the controls (0.95%) were currently presenting this symptom. These figures are too small to examine statistically but if those children who previously showed this symptom, (3 of the maladjusted and none of the controls) are included a Chi-squared of 18.6 $P < 0.001$ is obtained.

In the maladjusted group the symptom was present in 14.5% of boys and 2% of girls, a significantly different proportion. Corresponding figures for the combined control plus maladjusted/control groups (the population estimate) are boys 5.4%, girls nil.

Intersymptom correlations were 0.280 with food fads, 0.185 with excessive shyness and 0.179 with specific fears.

Illustrative Case:-

According to her fussy, overanxious mother, Pauline had an uneventful toilet training, beginning at the age of three months. By the age

of eighteen months she was clean by day and night nappies were discarded before the age of two years. Apart from occasional accidents she remained clean and dry until about the time her younger sister was born when she was $3\frac{1}{2}$ years old. She then began to soil her pants daily. At the same time she progressed from recurrent colds, which had troubled her since infancy, to 'asthma' attacks. Her soiling has continued with occasional remissions lasting only a few weeks followed by the return of daily soiling. The family doctor suggested that the soiling might be due to the strain of coughing during her now frequent wheezing attacks and her mother has accepted this explanation though there is in fact no temporal relationship between the two.

Pauline has always been regarded as a highly strung child with an inadequate capricious appetite and a number of food fads. As a toddler she was extremely shy and although she has gradually improved, remains shy and anxious in her social contacts. Until the age of four years she habitually manipulated a piece of silk, rolling it between her fingers. She became very distressed if anyone attempted to deprive her of her remnant and could never sleep without it. She has always been restless at night, often talks in her sleep and has occasional dreams. Since the age of 3 years she has had a habit of sucking her tongue when tired or preoccupied.

According to her mother she is a child who 'has to be loved', is always demanding demonstrations of affection and clings to her mother more than most children of her age. Although inclined to be quick tempered she has a small circle of friends with whom she plays happily and she had always liked school. She has a brother five years older than herself with whom she gets on quite well but she had always been jealous of her younger sister.

Her only separation experiences have been two three day stays in hospital at seven years and nine years, the first for tonsilectomy and the second for antral washouts which excluded sinusitis suspected because of frequent headaches. Apart from her recurrent wheezing which causesher surprising little disability, her general health has always been good.

Her mother is an extremely competent household manager but fussy and overanxious, fond of the children but inclined to overprotective, Pauline's father, to whom she is very attached, is a bus conductor who works regularly and is keen on promotion, though singularly lacking in success in this direction. He is a quiet homely man, fond of the children and with no interests outside the home.

9. APPETITE

(1) Inadequate appetitie, never hungry, hates eating, satisfied with small amounts.

(2) Below average appetite, variable, not interested. Never asks for food between meals.

3 Hungry at mealtimes, takes eating for granted.

4 Above average appetite, enthusiastic about food.

(5) Voracious eater, never satisfied, eats more than average. Often greediness beyond hunger.

CATEGORY	MALADJUSTED		CONTROL.		MAL/CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	5	2	1	1	1	2
(2)	8	6	0	3	2	2
3	20	20	15	23	2	2
4	37	17	38	15	9	0
(5)	6	5	5	4	1	1
6	2	0	0	0	0	0

AH. as Controls
(1) & (2)
$X^2 = 7.1$ $P < 0.01$
(1), (2) & (3)
$X^2 = 4.5$ $P < 0.05$

Voracious appetite · Inadequate appetite

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%	BOYS%	GIRLS%	TOTAL%
Maladjusted group	7.9	10	8.7	17.1	16.0	16.7
Control group	8.5	8.7	8.6	1.7	8.7	4.8
Population estimate	8.1	9.4	8.7	5.4	15.1	9.5

Problems of Appetite

According to Kanner (1957) "Though exact statistics are not available it may be safely assumed that at least a quarter of all children present feeding difficulties" and he quotes Tilson (1929) who found feeding problems in 28% of a group of pre-school children. Barllett (1928) found similar problems among 23% of children attending a paediatric Out Patient clinic but Shirley found the complaint of inadequate appetite in only 10% of his maladjusted group.

Inadequate appetite appeared in 21 of the maladjusted and five of the control group (X^2 7.1 $P < 0.01$) and occurred with almost equal frequency in both sexes. Excessive appetite was slightly more common in girls but not significantly so.

The only significant intersymptom correlations with inadequate appetite were 0.306 for food fads and a negative correlation of - 0.213 with tics.

Excessive appetite or gluttony had attracted little notice until the work of Bruch (1941) and Melœan (1941) who drew attention to the symptom particularly as a manifestation of insecurity or parental rejection. This symptom was seen in the present work with virtually equal frequency in both the maladjusted (8.7%) and control groups (8.6%) and thus it has not been possible to demonstrate an association between

this disturbance and maladjustment.

Illustrative Case

A) Harold is a small, restless, cross eyed boy who has been a feeding problem all his life. He was unable to feed from the breast, was a slow reluctant feeder on the bottle, and weaning was fraught with troubles. Always reluctant to sit down to a meal, he has to be coaxed and cajoled into eating and seems satisfied with small amounts. According to his mother 'its easier to tell you what he will eat rather than what he wont look at.' He will not eat meat or any vegetable, rarely eats fish and if left to himself, which he frequently is, would exist on bread and bought chips.

Since the age of three years he has soiled his trousers daily, initially passing a full, formed motion in his trousers but in recent years it has been the staining of overflow incontinence. Medical advice was not sought until the boy was nine years old when a large faecal mass was felt per abdomen. He is described as a jealous natured boy who is extremely sensitive and soon quarrels wi th his occasional playmates. Although he has not had any temper tantrums since the age of three years he is bad tempered and at times wilful and disobedient. He is attention demanding and must be the centre of attraction as indeed he is at home, where his mother and grandmother spend their time discussing and regulating the boys activities. His only pemitted regular

activity is said to be membership of the Junior Young Conservatives Club.

Harold has enjoyed excellent health but has had three periods in hospital, the first, for one month, at the age of 9 years, for the investigation of faecal incontinence, the second a few months later for 10 days when an unsuccessful attempt was made to correct his strabismus, and the third just before his 10th birthday when he spent a week in hospital because of faecal impaction. Apart from his hospital admissions he has only been once separated from his mother and that at the age of three weeks when his mother spent five weeks in hospital because of a breast abscess.

His mother is a small, cross eyed, untidily dressed woman who invariably exudes an offensive odour yet despite domestic incompetence and an unfortunate appearance she is a woman of good average intelligence. Since Harold started school she has worked full time as a hospital cleaner. She contracted a hasty marriage with the boy's father, who was a garage storekeeper, but continued to live with her domineering widowed mother. Father joined the household a few months before Harold's birth and left a few months afterwards. There was no further news of father until Harold was aged four when his father's death in an epileptic fit brought a welcome windfall to the household in the form of a widow's pension. Little else is known about the father.

B. Excessive appetite

Sylvia's eating habits have been a cause of concern since infancy, initially when she was described as a poor feeder and later when she refused to take solids. From the age of about ten months 'every meal was a pantomime', mother would sit coaxing and encouraging the child who would eventually take a mouthful and after carefully mulling it about her mouth spit it out again. During a 'meal' lasting over an hour the infant would spit and throw her food about the room whilst her mother became increasingly agitated, father's attitude of 'leave the bairn alone' adding fuel to mother's growing anger.

The child's attitude to eating has gradually changed and since the age of five years she has had an enormous appetite bordering on gluttony. She seems to be chewing all day and when no sweets are available she munches whatever she can find in the pantry but at mealtime still manages to eat more than her parents. From a small dainty infant she has developed into an obese clumsy schoolgirl with a weight at the upper extremity of variation for her age, though there is no evidence of disability as a result of her obesity.

This child's behaviour can only be appreciated against the background of the family. Her father is a quiet, hard working lorry driver

with no social pretensions whose one desire is to live a normal family life. His wife is a tense, histrionic, and neurotic woman who has been terrified of the prospects of childbirth since her teens and abhors the physical side of marriage. During the first thirteen years of her marriage she developed numerous gynaecological complaints, avoided intercourse whenever possible, and she regarded her pregnancy as a disaster. Throughout the pregnancy she had severe vomiting which necessitated her being nursed in bed for periods of up to ten weeks, she was terrified by the thought of her labour and used to cry herself to sleep every night. Sylvia was born by forceps delivery after a difficult labour and her mother remained disturbed during the puerperium being regarded by the maternity staff as a difficult and unco-operative patient.

From the moment of discharge from hospital mother has been fiercely overprotective towards the child, ruthlessly devoting all her energy and money to furthering the child's well-being and improving her social status, and attempting to manipulate anyone with whom she comes in contact to the same and. The child has been taken to or visited by her doctor at frequent intervals since birth, usually for trivial or non-existent complaints imagined by her mother.

Apart from her feeding disturbances, Sylvia has always been a very restless and overactive child. During her early childhood she often

lay awake all night but now sleeps normally, though she refuses to go to bed until her mother does so. Before the age of two years she began to have severe temper tantrums which have continued and she still has daily tantrums and which she screams, flings things at anyone and during which her mother claims to be terrified. Since starting to walk she has ruled the family, getting her own way as if of divine right.k She is irritable and easily upset, and when tense or upset she chews her gloves or handkerchief or sucks her thumb.

Since the age of four years she has had frequent and severe attacks of abdominal pain but thorough investigation as an out patient has revealed no organic basis for this. In the past two years she has also had frequent headaches. For several years she has worn glasses for reading but her visual acuity is 6 : 6 in both eyes.

At the age of three years she started to attend a private nursery school and at 4 years 4 months became a pupil at a private 'Grammar School.' She is of average intelligence and maintains a mid position in a 'B' form but failed her grading examination. For many years she has had regular instruction in elocution and ballet dancing and is now contemplating taking up riding.

The family originally lived in a small flat in deteriorating property in the East End of the city but mother insisted on providing something better for Sylvia than a new council house and somehow

managed to persuade a bachelor acquaintance to move in with the family and purchase a large terrace house on a respectable but fading thoroughfare. 'This 'uncle' remains with the family, contributing to the housekeeping and helping to subsidise Sylvia's activities. The house is furnished and maintained in what mother believes to be the fashion of the upper middle class producing the effect of a rather faded and neglected Victorian parlour. Since infancy the child has been protected from 'common children', including her relatives, and even her Grammar School friends are carefully vetted on their family background before they can be admitted to her circle.

Her tonsils were removed at her mother's request, when Sylvia was aged eight years, and she then spent three days in hospital. She has never had any serious illness, and her only other separations have been an annual three week holiday with her school since the age of five years.

Her father is an ordinary lorry driver with no particular ambitions who initially attempted to curb his wife's ambitions for the child but has long since abandoned them both to their fate. He is kept in the background and though he still feels that Sylvia should 'have a chance to be a normal kid' he no longer attempts to interfere in his wife's grandiose plans but works as much overtime as possible and hands

over his wages to his wife. The girl now treats him with disdain, criticising his speech, appearance, and eating habits but he shows remarkable restraint and simply moves into the next room to read his paper or watch television.

Superlatives are inevitable in summarising this disturbed family; the mother appears to view everything in life in terms of its effect on her child's social position. The child has been described as fantastically spoilt but it is difficult to understand how she is not even more seriously disturbed in view of her home environment.

10. FOOD FADS

(1) Extremely finicky, many active food aversions and refusals, resistive to all new foods. Habitual resistiveness to eating. Refuses one or two important items of diet, e.g. milk, meat, or practically all vegetables.

(2) Several food aversions, resistive to new foods. Fussing two or three times per week.

3 Eats most things, few dislikes, eats practically anything despite likes and aversions.

4 Actively interested in eating, tries new foods, may dislike onions, strong cheese, etc.

5 Never fusses, enthusiastic about foods.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL. /CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	8	5	1	4	2	1
(2)	20	10	7	7	1	2
3	19	11	13	10	5	2
4	11	13	23	14	3	1
5	18	11	15	11	4	1
6	5	2	0	0	0	0

Maladjusted as Controls $X^2 = 6.7$ $P < 0.01$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	36.8	30.0	34.0
Control group	13.6	24.0	18.1
Population estimate	14.9	26.4	19.7

FOOD FADS

Eating habits are usually considered under a single heading but despite a strong association between inadequate appetite and food fads they are considered as separate symptoms and some justification has been found for this. In fact, food fads proved to be commoner than complaints regarding appetite and have somewhat different associations.

Symptoms were found in 43 of the maladjusted group and in 19 of the control group ($X^2 = 6.73$ $P < 0.01$). In the maladjusted group 36.8% of the boys and 30% of the girls were affected whilst in the controls the symptom was commoner in girls (24%) than in boys (13.6%) The population estimate of incidence is 14.9% for boys and 26.4% for girls.

Intersymptom correlations were 0.306 with abnormal appetite, 0.280 with faecal soiling, 0.256 with emotional dependance, 0.228 with shyness, 0.208 with overactivity, 0.205 with undue reliance on others, 0.189 with excessive reserve and 0.184 with instability of mood and temper.

Illustrative Case Charles F.

This boy's eating habits have been a source of worry since early infancy when mother's breast milk wasn't feeding him and he was put on the bottle. Although every brand of artificial milk available was tried he remained a poor eater. When solids were introduced the battle

continued and several foods were found to 'disagree with him'. He did, however, slowly improve in appetite but developed numerous food fads. By the age of four years his fads were such that his parents could not take him on holiday because he was so awkward about what he would eat. In recent years there has been a considerable improvement but he still refuses to eat any vegetables, is reluctant to eat meat, and rejects all fish except lemon sole cooked specially for him by his mother. His parents still feel unable to take him into a restuarant for a meal, yet at school he stays for lunch and accepts anything offered to him.

From birth he has been restless throughout the night and until a year ago wakened his parents at least once a night. Now whilst he is still restless he no longer troubles his parents. During the day he is restless and unable to sit still, and even when enthralled by a television programme he moves from chair to chair constantly fidgetting. His mother claims that he has always bitten his nails to the quick and he frequently develops paronychiae as a result of this habit.

Charles is very attacked to his mother, follows her all over the house and often follows her when she goes out shopping even at times when she has asked him to remain at home. He would always prefer to be nurshd by his mother than go out to play. He is extremely tidy with toys and clothes, and after undressing at night he carefully folds his

clothes and places them in a regular arrangement. Until recently he was rather timid and unable to join groups of children, but stands on the fringe of a group unless invited to join them and left in tears if they moved away from him. Recently however he has become something of a daredevil taking risks which appall his mother though he remains shy with strangers, reluctant to meet people and is still afraid of the dark and easily upset by unexpected noises. At home he has long been bad tempered, flying into a tantrum if things do not go as he wants but these outbursts are becoming less frequent, and occurring now only once a week. He likes to show off with people he knows and is very attention seeking. At school, which he has always enjoyed, he maintains a middle position in class.

His mother spent two periods of five days in hospital during his sixth year and when he was nine years old she entered hospital for a thyroidectomy and stayed two weeks. He himself spent three days in hospital at the age of 10 years. When his tonsils and adenoids were removed.

Charles is the only child of his mother's second marriage, her first husband having been killed in the first year of their marriage just after a daughter was born. Mother is a fastidious, anxious woman who throughout the past elevenyears has been under the care of her family doctor and various specialists for 'nerves', hyperthyroidism and

anxiety states. She never stops work in the home and admits that she cannot relax, and a health visitor described her house as 'the tidiest house I have ever seen'. Father is a skilled craftsman who works regularly and devotes all his spare time to the home and garden. He considers himself as a 'worrity type' and has had treatment from his G.P. for 'nerves'.

11. TICS

(1) Compulsive pronounced tics or mannerisms occurring every day. Severe enough to compel attention.

(2) Less obvious or frequent than (1) but habitual and moderately severe.

(3) Consistently resorts to tics or habits when overfatigued or under stress.

4 Few transient mannerisms, e.g. occasional eye rubbing.

5 No mannerisms.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	7	0	0	0	1	0
(2)	12	4	5	1	1	0
(3)	12	5	3	6	3	1
4	14	6	7	3	1	2
5	31	35	44	36	9	4
6	6	6	3	0	1	3

Maladjusted as controls.
$X^2 = 8.5$ P(0.01

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	40.8	18.0	31.7
Control group	13.6	15.2	14.3
Population estimate	17.6	15.1	16.5

Diff. = 2.69 times stndard error

TICS

Boncour (1910) quoted by Kanner found tics in 23% of a group of children aged between 2 and 13 years, but Ackerson found an incidence of mannerisms in 5% of girls and 6% of boys in his group. Pasamanick and Kawi (1956) examined the records of all tiquers seen at the Harriet Lane Children Psychiatric Service who had been born since 1926. Records of 83 children were found, 65 (78%) of whom were boys. These authors regard tics as 'among the less common neuropsychiatric disorders of childhood'. In this country Craig (1956) reported tics in 21% of a group of 200 maladjusted children seen in a Paediatric clinic and Lewis (1954) found precisely the same incidence in a sample of deprived children admitted to a Reception Centre.

The symptom was seen in 40 of the maladjusted group and 15 of the controls (X^2 8.5 $P < 0.01$), and eleven and two children in the respective groups had a history of previous symptoms. In the maladjusted group 40.8% of boys and 18% of girls showed the symptom, a significant sex difference which did not appear in the control group where 13.6% of boys and 15.2% of girls were in the symptom categories.

Intersymptom correlations found were 0.225 for overactivity, 0.224 for lying, and a negative correlation of - 0.213 with inadequate appetite.

Illustrative Case

Since the age of $2\frac{1}{2}$ years, Michael has had a series of nervous tics beginning with blinking of his eyelids which continued for several months and led to several visits to his doctor and hospital out patient department. Later he added head shaking, nose twitching, shoulder shrugging, sniffing, and nervous cough to his repertoire and various combinations of these have been present ever since. The habits are always noticeable and become more marked if anyone is watching him.

At about the time that his tics started, he became very restless at night, was frightened of the dark and began to have nightmares. These gradually subsided over the course of a few months and did not recur until he was 5 years old, a few months after the birth of his only sister. Then the attacks began to occur nightly, he would scream in his sleep and be found in a state of terror, soaked in perspiration, and often complaining that there was blood in his throat. At about the same time, he complained for a few weeks that he had noises in his ears during the day and had to pull his face and twitch his eyes in order to stop the noises. His nightmares continued unabated for over two years and then gradually diminished in frequency until he now has severe nightmares about twice a month.

As a toddler he had frequent temper tantrums but since starting school his temper is better controlled and though still quick tempered he flares up only occasionally. He is extremely jealous of his younger

sister and inclined to make a scene if he thinks she is getting too much attention.

At school he is inclined to be fidgetty and restless but has done quite well and now attends a selective Technical School.

He is a healthy, active youngster who has had no serious illnesses, but just after starting school he had a number of attacks of tonsillitis and at $6\frac{1}{2}$ spent 3 days in hospital for removal of his tonsils and adenoids. Six months later he spent a further 4 days in hospital for investigation of cervical adenitis which proved to be pyogenic.

His mother, who has done some part time work in a shop since he was 2 years old, is a pleasant capable woman, who appears to cope well with her home and family. She has always been superficially co-operative and apparently frank but it is difficult to establish a relationship with her or to assess her personality. The boys father was invalided out of the army on full pension but is evasive as to the precise nature of his disability. He has not suffered any ill health since the boy was born and has never been unemployed though he has changed his job, usually as a semi-skilled machinist, at least six times in ten years.

The family lived with the maternal grandparents until Michael was aged eight years and now live in a comfortably furnished council house. No one connected with the Survey has ever seen these parents together and they take their holidays separately, each taking the children for a part of their holiday.

12. NAILBITING

(1) Extreme and persistent biting of nails or cuticle. Fingers disfigured, chewed to 'the quick'.

(2) Nails kept chewed down. Not so severe as (1), no disfigurement.

(3) Mild persistent biting, always evidence of chewed nails.

(4) Mild nail biting or pulling of rough nails.

5 No nail biting.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	10	4	4	0	3	0
(2)	12	8	5	7	3	1
(3)	6	4	4	6	1	2
(4)	1	3	1	2	2	1
5	47	31	45	31	6	3
6	3	2	5	4	0	0

$X^2 = 2.4$
Not significant

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	38.1	38.0	38.0
Control group	23.7	32.6	27.6
Population estimate	31.1	35.8	33.1

NAILBITING

Nailbiting is frequently included in lists of 'neurotic symptoms' and is prominent among the neurotic traits enquired into in psychiatric histories. Ackerson (1931) reported nailbiting in 12% of the boys and 18% of the girls in his group. Massler and Malone (1950) however found that 80% of a group of World War II inductees were actual or former nailbiters and estimated that the incidence among schoolchildren exceeded 40%. Birch (1955) in a survey among schoolchildren in Northern England found that 54% of boys and 46% of girls were nailbiters at the time of enquiry.

In the present study there was no significant difference between the incidence in the maladjusted and control groups. The symptom was seen in 31.8% of boys and 38% of girls in the maladjusted group and 38.1% of boys and 38% of girls in the control group. A population estimate would be 31.1% of boys and 35.8% of girls.

Illustrative case

Billy is said to have been a nailbiter since he acquired his teeth and though this may be an exageration his nails were certainly well chewed by the age of four years. They are now deformed, always 'chewed to the quick' and sore, the excoriated skin frequently becoming infected. Since the age of two years he has also sucked one or other forefinger,

he has a finger in his mouth most of the day and can often be heard sucking loudly during the night.

As a toddler he had a phase of marked aggression towards other children, has remained bossy, and must always be 'top dog' in any group consequently having very few friends. He is a fidgetty, restless boy unable to sit still for a minute and at play he is active and generally overadventurous undertaking foolhardy tricks in order to impress other children. Perhaps as a result of this he is very heavy on clothes while quite cæful with his toys and other belongings. He has a markedly possesive attitude and strong reluctance to sharing. His clothes also suffer as a result of his habit of picking at them, pulling out woollens and twisting off buttons.

Since the age of 8 years he has wandered off on his own a good deal and his parents are often worried by his absences. He wanders considerable distances, up to twelve miles, perhaps two or three times a month and an equal number of times he will be missing in nearby parks or fields. When he travels away from home he usually goes by bus or train, often not paying his fare.

He settled well at school until a few weeks before the grading exam at $10\frac{1}{2}$ years, when he refused to go. His parents tried to force him but he alternated between stubborn refusal and tearful panic, and it was only after three weeks that he could be persuaded with considerable

difficulty to return to school. Within a few weeks his anxiety settled and he was able to sit the examination without further upset.

Billy is normally an extremely independent lad whose parents consider him rather forward and lacking in shyness. Temper tantrums started whilst he was a toddler, he still has a 'wicked temper' and can be difficult to control during his outbursts. He has always been regarded as spoilt, disobedient, and at times extremely defiant, he will often refuse to run errands for his mother who may have to take a meal out of the oven in order to do the shopping herself. For the past few months his mother has been worried by his habit of frequently touching and playing with his genitalia and the boy is very shamefaced when checked for this.

He has never had any serious illness but in recent years has seen his doctor several times because of either infected fingers or recurrent headaches. His only separation experience was at the age of 10 years when his parents had two weeks holiday together.

His brother and sister are respectively 7 and 14 years older than himself and they often quarrel with him because of his bossiness. Both his parents are simple, limited people but his mother keeps the house clean and provides good meals whilst father works regularly as a labourer. The house is tidy and sparsely furnished but the atmosphere of the home though uninspiring is essentially friendly and warm.

13. THUMB SUCKING

(1) Persistent vigorous thumb sucking occurs major part of the time. Skin waterlogged.

(2) Thumb in mouth at least 15 minutes daily.

(3) Sucks thumb daily, usually when tired or upset but not so much as (2).

4 Mild episodes of thumb sucking not occurring daily.

5 Never sucks thumb.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	3	0	0	0	0
(2)	0	0	0	1	0	0
(3)	2	2	0	2	2	0
4	0	1	0	0	0	0
5	72	44	59	43	13	7
6	3	3	2	0	2	0

Affected as Controls

$X^2 = 2.9$

Not significant

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	5·3	10.0	7.0
Control group	Nil	6.5	2.9
Population estimate	2.7	5.7	3.9

THUMB SUCKING

Thumb sucking is a normal manipulation in infancy and can probably be found to some degree in all infants but the incidence decreases rapidly with age. Ackerson (1931) found thumb sucking in only 2% of his large maladjusted group. Levy (1928) believes that the habit is established in infancy and is related to oral gratification and adequate sucking time, the infant who has short daily feeding times tending to suck his thumb or fingers.

The symptom was found in nine of the maladjusted group, (with six previous offenders) and three of the control group in which two children had a past history of thumb sucking. Even combining active and previous thumb sucking the difference between the two groups is not statistically significant. Thumb sucking before the age of two years has not been included in these figures.

The percentage incidences given in the tables must be viewed with caution as they are based on small numbers.

Intersymptom correlations were 0.185 with disobedience, 0.177 with overactivity and a negative correlation of - 0.268 with excessive sensitivity.

Illustrative Case Anne D.

Anne has always sucked her thumb. It is in her mouth intermittently

throughout the day but always when she is excited or under stress and she is unable to sleep without her thumb firmly in place. As a result, there is marked flattening of the terminal phalanx of both thumbs and the skin is often soggy and excoriated but no deformity of her teeth has occurred.

She is the first child of a substantial middle class couple. After a moderately difficult forceps delivery she thrived normally until the age of eight months. At this time she developed what was thought to be a severe cold with slight diarrhoea and vomiting and this was treated as such by her family doctor. Her condition steadily deteriorated and on the 19th day of her illness the onset of lsided fits precipitated her admission to hospital where a diagnosis of meningococcal meningitis was confirmed. After several weeks of intensive treatment, including a third ventriculostomy, the infant slowly recovered and was discharged home after seven weeks in hospital. On discharge, she had a moderate internal hydrocephalus and a mild left hemiporesis.

Since her second year she has shown emotional lability, varying between boisterous happiness, and temper outbursts with little provocation, is restless and overactive, bites her nails and has a habit of grimmacing. Despite her temper and petulance she mixes well with other children and is a little uninhibited in her social contacts. For

several years she has worn a caliper on her weak left leg but tries to keep up with other children in all their activities and bridles at anyone who expresses sympathy or makes allowances for her disability. She is jealous of her brother, who was born when she was four years old, and tends to bully him.

During her seven week stay in hospital she was visited daily by her parents and has never been separated from them on any other occasion. Her general health and development have been surprisingly normal since her meningitis and despite her disability she has been able to hold her own at a normal school.

Anne's father is a stable, extroverted senior executive with a fairly realistic view of her difficulties. His wife, a comfortable intelligent Scotswoman, has always been anxious to accept advice and prognostications on the child's development and has coped very well but despite apparent acceptance of Anne's intellectual impairment, she never ceases to strive for improvement. At 10 years the girl's I.Q. was estimated (W.I.S.C.) at 87 with a wide sub test scatter and particular difficulty in the use of symbols. In view of this, her parents were advised not to press her at school and in particular to leave her at an ordinary secondary modern school where she had settled happilly. In spite of full discussion and apparent acceptance of this situation mother has gone to considerable trouble and expense to secure the child's

admission to a fee paying Grammar School. During the past year mother, a previously stable person, has developed anxiety symptoms with depression and is now under psychiatric supervision.

14. MOTOR ACTIVITY

(1) Extreme overactivity and restlessness, regarded as a nuisance.

(2) Above average in restless activity, seldom sits to play, noticeable by anyone.

3 Normal activity.

4 Underactive, either lack of energy or preoccupation.

(5) Extreme inactivity, walks slowly, never runs, inert.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL. /CONT.	
	MALE	FEMALE	MALE	FEMALE	MALE	FEMALE
(1)	11	5	2	1	2	0
(2)	28	14	9	6	9	2
3	33	30	45	39	4	3
4	3	0	2	0	0	2
(5)	1	1	1	0	0	0
6	2	4	0	0	1	1

Maladjusted as Controls

$X^2 = 20.8$
$P < 0.001$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%	
Maladjusted group	51.3	38.0	46.0	(Diff. = 1.47 x se)
Control group	18.6	15.2	17.1	
Population Estimare	29.7	17.0	24.4	(Diff. = 1.65 x se)

MOTOR ACTIVITY

Ackerson (1931) recorded restless overactivity or hyperkinesis in 25% of boys and 21% of girls but Craig (1956) found the symptom in only 4.5% of his group. In this study restless overactivity was recorded in 581 of the maladjusted group but only 18 (17%) of the controls ($X^2 = 20.79$ $P < 0.001$), one of the most striking differences obtained in the study. The symptom was present in 51.3% of the boys and 38% of the girls in the maladjusted group whilst in the control group it was seen in 18.6% of boys and 15.2% of girls. For the population estimate the figures are 29.7% for boys and 17% for girls.

Intersymptom correlations were 0.424 with irritability, 0.322 with wandering, 0.318 with temper, 0.295 with instability of mood, 0.292 with disobedience, 0.225 with tics, 0.210 with nocturnal enuresis, 0.209 with lying, 0.208 with food fads, 0.198 with emotional dependance, and 0.177 with thumb sucking.

Extreme inactivity was recorded in only three children, one boy and one girl in the maladjusted group and one boy in the control group.

Illustrative cases . Janet

Janet is a fidgetty, restless child who literally can not sit still. Her constant aimless restlessness results in frequent scoldings at home, where the mother finds her incessant movement 'bad for my nerves',

and at school where it has been seriously suggested that she must have St. Vitus Dance. Although she has always been an overactive child she is not energetic in her normal routine and often can not be bothered to play with other children. At night she is restless, constantly tossing and turning, kicking the bedclothes onto the floor and talking in her sleep.

Janet has been described since infancy by many different observers as a sad unhappy looking child and though her mother believes that she is often quite cheerful she has never been seen in this state. According to her mother, she has very frequent mood swings with periods of real depression in which she is weepy and 'nother will cheer her up'. She is extremely shy with both adults and children, liable to remain mute in company, unable to mix and with no real friends. When with children known to her she soon quarrels with them and leaves the group. She is extremely timid and terrified of any violence.

At home, although obedient she is irritable and quick tempered, screaming and stamping her feet when annoyed. She is extremely sensitive, 'takes the least thing to heart' and is jealous of the other children. Apart from her finger nails which are always well chewed down, she takes a pride in her personal appearance, her personal possessions are always tidy and well cared for though she is inclined to give her things away rather easily. With her mother she is

clinging and affectionate, following mother all over the house and showing little or no independance.

Janet is the youngest of a family of four and has three younger step-sisters. Her own father left the household when she was six months old but continued to visit weekly in the hopes of reconciliation until Janet was two years old. He then returned to his native Scotland and has made no attempt to see his children since.

Her mother is a harsh, psychopathic individual with no real affection for her children. 'Regarded by her own parents as a 'loose living woman', she has had two illigitimate children and has been promiscuous during both her marriages. Her first marriage broke up because of her promiscuity and her second, to the father of one of her illigitimate children, has not interrupted her way of life. Janet does not get on well with her stepfather who is a coarse, gruff individual with a harsh manner toward the children.

Of her three elder siblings, the eldest boy was committed to an Approved School for theft following two breaches of probation, the next, a girl, is in an Approved School because of sexual middemeanors, and the other boy suffers from migrane, 'black outs' (non-epileptic) and an inability to hold a job.

At the age of five months Janet spent a week in hospital for the investigation of 'colic', four months later she was in hospital for ten days because of enteritis and during her second year had a further

two weeks in hospital with an upper respiratory tract infection. When aged five and a half she developed rheumatic fever and was in hospital for two months. Since then she has had no serious illness but is frequently troubled with headache and abdominal pain.

From the age of a year and five months until starting school she attended a day nursery whilst her mother worked. Since the age of three years she has been separated from her mother for at least ten periods of over a week in duration, usually due to her mother being in hospital or convalescing following some obstetric adventure.

Illustrative Case

During the past few years George, an only child, has become increasingly apathetic, whereas in earlier years he played normally and energetically, he now moves like a weary old man. His mother thinks that this is due to lazyness but that he is now so used to his attitude of lethargy that he could not run if he tried. He is becoming rather plump and flabby and his weight is near the upper range of normal. Formerly he had an active circle of friends but now he will not trouble to go out and play with them, prefering to loungearound the house reading or watching television.

During the night he is a good deal more active, twisting, turning and moaning most of the time with occasional night terrors. His appetite is enormous and he eats far more than either of his parents.

At the age of two and ten months he began to wander away from home, being brought back on several occasions by the police, having been found wandering on railway property or major roads, but has been no trouble in this respect since about the age of four years.

A placid easy going boy, he is rather shy, a model of obedience extremely careful with his clothes and toys, and rather selfish with his belongings, refusing to share anything he considers his own. He is an extremely cautious child who will never risk getting into trouble and is physically timid, he would never climb a tree 'in case I fell down'. Any change in his routine of life at home and at school creates great anxiety until he settles into the new situation. At home he is his mother's shadow, very dependant upon her and becomes very upset if she goes anywhere without him. Although normally truthful, he romances to other children and to teachers at school, the stories are usually concerned with exciting trips and adventures he claims to have made with his father.

He has been free from serious illness though he spent five days in hospital at the age of five years to have his tonsils removed. His father worked away from home for three months when he was aged three years but he has never been separated from either parent on any other occasion.

His mother, who always speaks of him as 'our little George' is a tense, nervous woman, generally timid and very much dominated by her

husband. She maintains a spotless, well run house but has never been able to develop any outside interests. For a number of years she has been under treatment from her family doctor for 'nerves' and always feels miserable though she has never been able to cry.

George's father is an odd, solitary man who often goes for weeks without exchanging a word with his wife, sometimes following a minor tiff but more often there is no obvious reason. He is very suspicious and surly with any visitors to the house and many of his wife's friends have stopped coming. He resents his wife going out alone and often orders her to stay at home. When in the house alone he will not answer the door and he never goes out except to his work as a plumber. So far as is known he has never sought advice for nervous troubles though he did spend three weeks in an R.A.F. hospital allegedly for the investigation of nail biting.

15. WANDERING.

(1) Wanders off against orders more than once a week, or long distances (more than two miles) three or more times in six months.

(2) Once a week wanders from home or wanders long distances twice in six months.

(3) Wanders short distances once a month. One long distance trip in six months. More than three-quarters of an hour.late from school more than half of the time. "Rationalised wandering", i.e. initial wandering followed by frequent long distance, solitary excursions with permission, e.g. train spotting, etc.

4 Up to two or three times a week goes to friends house without permission. Once or twice a week slow in returning home from school.

5 Practically never away or late without permission.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	8	0	1	0	3	0
(2)	4	1	0	0	2	0
(3)	10	1	1	0	0	0
4	5	4	9	1	4	0
5	49	44	48	45	6	7
6	6	1	1	0	3	0

Maladjusted as Controls.
$X^2 = 15.2$
$P < 0.001$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	28.9	4.0	19.0
Control group	3.4	NIL	1.9
Population estimate	9.5	NIL	5.5

Diff.= 3.49 times standard error

Diff.= 2.33 times standard error

WANDERING

The incidence of 'truancy from home' is not readily available though Lewis (1954) found a history of wandering or truancy in 22% of her Mersham sample. Whilst Craig (1956) apparently did not find this symptom in his study of 200 maladjusted children. In America Ackerson (1931) found 'truancy from home' in 16% of boys and 10% of girls. In child guidance clinics the symptom is often equated with a poor prognosis and it certainly correlates very highly with maladjustment as seen in this study. Twenty four of the maladjusted group and only two of the controls are found in the problem categories (X^2=15.2 $P < 0.001$). The symptom is much commoner in boys than girls having been found in 28.9% of boys and 4% of girls in the maladjusted group, 3.4% of boys and none of the girls in the control group, and 9.5% of boys and no girls in the population estimate, the sex difference in the maladjusted group and population estimate being statistically significant.

Intersymptom correlations were 0.322 with motor overactivity, 0.279 with undue reliance on others, 0.264 with stealing, 0.202 with temper and 0.196 with disobedience.

Illustrative Case Henry K

Although this boy occasionally wandered away from home in his

early years his more ambitious wandering started when he was about eight and a half years old. Since that time he has ranged far and wide by bus and train, his movements are completely unpredictable and his parents never know when or how he will return home. He is a well known character to local transport crews who permit him to travel free, though how he manages this on British Railways where he often rides with the engine driver remains a mystery. His mother finds it embarrassing to go into town with him as bus drivers are liable to stop their vehicles, hailing the boy by name, to pass the time of day. One driver and conductress who married recently invited Henry to the wedding and he now often visits the couple at home. Despite being backward and lacking in interest at school, he has committed to memory all the local bus and train time tables.

He is a boy of tremendous energy who is always 'on the go' and incapable of sitting still. At night he is equally restless, talks in his sleep and has frequent disturbing dreams with nightmares on average twice per week. Because of these disturbances he refuses to sleep in a room of his own and sleeps on a spare bed in his parents' room, often creeping into their bed at night. Although independant in many respects, he clings to his mother when at home and annoys her by trying to kiss her on what she considers to be inappropriate occasions. He requires a good deal of help and encouragement with even simple tasks

which he can perform efficiently when alone and can never concentrate on a task for long. A rather timid child in many ways, he is invariably solitary in his play and is terrified of the dark or noises in the night, sometimes becoming quite hysterical because of imagined ghosts.

In his earlier years, before starting school, he was extremely destructive and aggressive towards other children. He is very jealous of his sister, who is three years younger than he and is often cruel to her. At school he settled quickly but is restless, daydreaming and lacking in concentration and in recent years has been regarded as backward. Recent psychometric testing demonstrated dull normal intelligence with a rather wide interest scatter (W.I.S.C.) He has never had any serious illness but for many years has had frequent tonsillitis and recurrent otitis media. At five years he spent three days in hospital whilst his tonsils were removed and at three years his mother spent two weeks in maternity hospital.

His mother is a pleasant but tense and overanxious woman who has worried incessantly about the boy since he was found to have web toes at birth, and she is constantly on the look out for other abnormalities. She had been under psychiatric supervision for several years with a diagnosis of 'depression' and has had two courses of electroconvulsive therapy.

Henry's father is a rigid overbearing man who works as a senior

executive in a bakery. Initially he made high scholastic demands on the boy but has now "written him off". He spends little of his time at home and has never played with either of the children. His wife appears to have an equally detached relationship with him, the only positive affective element being fear of her husband.

16. TRUANCY

(1) Habitual truant, once per week or more.

(2) Truants more than three times in 6/12 on average.

(3) Truants one to three times in six months or persistent school refusal.

4 One episode of truancy in past year or difficult to get to school.

5 Never truanted.

6 Previous symptoms

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL.		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	1	0	2	0
(2)	0	1	1	0	0	0
(3)	7	2	3	0	1	0
4	7	5	3	0	2	1
5	60	42	51	46	10	6
6	6	1	1	0	0	0

Maladjusted as Controls $x^2 = 1.28$ Not significant

If those with previous symptoms included $x^2 = 4.3$ $P < 0.05$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	total%
Maladjusted group	11.8	6.0	9.5
Control group	8.5	NIL	4.8
Population estimate	10.8	NIL	6.3

Diff. = 2.48 times standard error

TRUANCY

In the United States Ackerson (1931) found a history of truancy in 25% of boys and 9% of girls in his clinic group. In this country Magnay (1959) comments that whilst the percentage of school attendance has risen steadily since 1920 the percentage of truancy has remained remarkably constant. In Liverpool 1% of pupils truanted in 1920 whilst for the Spring Term of 1959 the percentage was 0.74%

The figures obtained in this study give a somewhat gloomier picture comprising twelve current truants and seven former offenders in the maladjusted group and five current and one previous offenders among the controls. If past and present truants in each group are taken together $X^2 = 4.3$ $P < 0.05$. A notable feature is that none of the girls in the control group were truants. 11.8% of boys and 6% of girls in the maladjusted group had a recent history of truancy, as had 8.5% of boys in the control group and 10.8% of boys in the population estimate.

This symptoms was not included in the correlation matrix and so no intersymptom correlations are available.

Illustrative Case Oswald R.

Oswald, an only child, settled quickly when he started school and went off happily each morning. When an Education Welfare Officer visited the home to inquire why the boy had been absent from school for two full

months at the age of six and a half years, his parents were astonished, especially when they discovered that he had been a poor attender since starting school. When the lad returned home 'from school' he vigourously denied any absence and his parents were almost convinced when he suddenly broke down and told his story. He had been leaving ostensibly for school each morning but spent the day wandering about the city and surrounding countryside always returning at the appropriate time for lunch and after school time in the evening.

Since this episode, his parents have made an effort to secure his regular attendance but he continued to evade their supervision and always manages to truant several days per term. Until the age of about seven years he was regarded as a bright mischievous youngster but on transfer to a new school was found to be somewhat retarded and this was initially attributed to a difference in teaching methods and curriculum Since this time he has remained in a backward group within a normal class but has not been ascertained as educationally sub-normal.

Oswald's toilet training was uneventful and he achieved full control by the age of eighteen months, but at two years he began to wet the bed and continued to wet nightly until the age of three years. From then until the age of eight and a half he had several episodes of bed-wetting each lasting some months but has been dry at night since.

His wandering is not entirely associated with truancy from school.

He first began to disappear from home at the age of three years and since then has often been missing for several hours. He is only missing for long periods about once a month on average, but would vanish more frequently were he not constantly supervised. It is impossible to find out what the boy gets up to during his wanderings because he can never be relied upon to tell the truth. He has always been a ready evasive liar and romances a good deal both at home and at school. His nails have always been well bitten down and in recent years he has developed the habit of chewing his shirt or jacket collars. Although he enjoys playing with other children he is jealous, inclined to be quarrellsome and has few regular friends.

Oswald has never had any serious illness but has experienced considerable separation from his mother as will emerge.

His parents were both under twenty when they married six months before he was born. For the first three years of Oswald's life the family lived in with his maternal grandparents, and then moved to the paternal grandparents where they stayed until Oswald was seven and a half years old. Whilst his father continued to work as an apprentice pattern maker his mother returned to her job in an office when the boy was a few months old. The baby was largely cared for by his maternal grandmother until he was eight years old for though he normally lived with his parents when they moved he continued to spend each day at his

maternal grandmother's and slept there most nights.

When Oswald was five and a half years old his mother was found to have active pulmonary tuberculosis. She gave up her job and was admitted to a sanatorium where she remained for ten months. At the age of seven and a half years Oswald's parents moved into a home of their own and for the first time really accepted responsibility for the boy's care. Within a few weeks mother returned to part time work and after a year resumed the old full time job.

Mother is an immature young woman who copes moderately well with the physical management of the household. She is however ineffectual and anxious in dealing with the boy's difficulties and has never had a close relationship with him. Father is a quiet, self effacing man who works regularly and appears to get on well with his son at a superficial level but has never been able to discipline him.

17. LYING

(1) Frequent habitual lying. Compulsive lying serving no immediate purpose or lying characteristic pattern to gain own ends.

(2) Lies more frequently than average, lies habitually in any emergency.

(3) Lies to avoid trouble or make good impression and/or romances a good deal.

4 Lies under stress but usually admits truth under pressure.

5 Never lies.

6 Previous symptoms.

ACTUAL NUMBERS IN EACH GROUP

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	5	1	1	0	1	0
(2)	7	3	1	2	5	0
(3)	8	11	6	4	2	0
4	12	4	13	7	0	2
5	44	31	38	33	7	5
6	3	2	3	0	0	0

Maladjusted as Controls.

$X^2 = 6.34$ $P < 0.02$

PERCENTAGE IN SYMPTOM CATEGORIES

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	26.3	30.0	27.8
Control group	13.6	13.0	13.3
Population estimate	21.6	11.3	17.3

LYING

Lying was recorded in 25% of boys and 23% of girls in Ackerson's (1931) study. English authors seem reluctant to define this symptom, and no corresponding figures could be found for this country.

Thirty five of the children in the maladjusted group and fourteen of the control group were included in the symptom categories ($X^2 = 6.34$ $P < 0.02$). There was little difference in sex incidence within the two groups, there being 26.3% of boys and 30% of girls among the maladjusted group and 13.6% of boys and 13% of girls in the control group. In the population incidence the difference is more marked because there were fewer girls with symptoms in the overlap group giving figures of 21.6% for boys and 11.3% for girls.

Intersymptom correlations were 0.405 with stealing, 0.249 with instability of mood, 0.224 with tics, 0.209 with nocturnal restlessness and motor overactivity 0.197 with diurnal enuresis, 0.195 with temper, 0.194 with reluctance to shave, 0.192 with irritability, and 0.178 with disobedience.

Illustrative Case David G

David is a boy who lies easily and apparently without purpose. His parents find it impossible to believe anything he tells them as he lies automatically even when there is no obvious gain to be achieved.

His lying pervades his whole life both at home and at school.

He has always had a variable appetite with a few minor food fads and is a persistent nail biter. From an early age he frequently played with his genitalia and later began to masturbate, being very secretive and shamefaced about this, but his father "managed to break him off" by the age of eight years. Since starting school he has often been missing from home for periods of several hours, but never strays further than the local parks and over the past year has usually obtained permission before going off for long periods. Although normally quite cheerful and good tempered he is easily upset and very sensitive to criticism, real or imagined. He is an extremely restless boy and cannot sit still or concentrate; he roves about the room even when watching television and can never settle down to read a book. For several years now he has had the habit of screwing up his face and he does this frequently during the day. 'No amount of checking with stop him.'

At the age of eight years he began to soil and wet his trousers by day and was nocturnally enuretic. The soiling has gradually disappeared over the past year but he still wets his bed about once a month and his trousers every six weeks or so. He gets on quite well at school despite his inattentiveness and has been transfered to a selective (commercial) school.

David has never had any serious illness and has only seen his

doctor because of minor ailments. He had no separations from his mother until her sudden death, when he was two and a half yeard old, brought about a major family upheaval. His only separation from father was during his tenth year when his father spent ten weeks in hospital.

His father is a quiet rather brüsque man who suffered irregular employment as a casual labourer until David was four years old when he obtained a regular semi-skilled job with an Electricity Board. David's mother was a warm capable girl who managed him and his sister, a year younger, very well until her sudden death from coronary thrombosis when the boy was two and half years old.

On mother's death, the family moved in with father's sister in law and David was sent to a day nursery which he continued to attend until starting school. Although David became attached to his aunt, a rather coarse uninhibited woman, his father had frequent disagreements with her and the family returned to their own home when David was six years old. A year later his father married a kindly pleasant young woman who initially got on well with the children. The step-mother became increasingly perplexed by David's behaviour which became worse with the arrival of her own son a year after the marriage. She has however gradually established a reasonable relationship with the boy and he is generally more settled.

18. STEALING

(1) Persistent stealing with total disregard of property rights.

(2) Chronic petty pilfering whenever opportunity presents.

(3) Occasional episodes of pilfering.

4 Occasionally careless of returning 'borrowed' or found property.

5 Never takes anything. Very honest.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL.		MAL./ CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	1	1	0	1	0
(2)	2	0	0	0	0	0
(3)	12	1	3	0	4	0
4	1	3	4	1	1	0
5	59	45	51	45	9	7
6	1	1	1	0	0	0

Affected as controls

$X^2 = 6.2$ $P < 0.02$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	21.0	4.0	14.3
Control group	6.8	NIL	3.8
Population estimate	12.2	NIL	7.1

Difference = 2.67 times standard error

Difference = 2.65 times standard error

STEALING

Ackerson (1931) reported stealing in 31% of boys and 17% of girls in his group, but the age range was up to seventeen years and 14% of the referals were associated with "police arrest". Among 500 'deprived' children admitted to a Kent Reception Centre pilfering was the official cause for admission in 10% of cases and ina sample of these children examined in more detail no less than 28% had a past history of pilfering (Lewis, 1954).

Intersymptom correlations were 0.405 with lying, 0.284 with reluctance to share, 0.264 with wandering, 0.218 with destructiveness 0.208 with quarrellsomeness, 0.176 with instability of mood, and a negative correlation of - 0.238 with fears.

The most striking finding is in the sex difference, 21% of boys and only 4% of girls in the maladjusted group showing this symptom while there were 6.8% of boys and no girls affected in the control group. In the population estimate 12.2% of boys and no girls were found to be affected. These differences are statistically significant in each group.

Illustrative Case

Hazel, the third child in a family of six with a poor background of observation and discipline was first noticed to be stealing money

from her mother's purse at the age of nine and a half years. She either spent the money on trivialities or gave it away to other children and was not unduly disturbed when caught and punished by a thrashing from her father. The stealing continued despite dire threats from her parents and she was also suspected of theft from other children and a shop. At the age of ten years she was found to have been responsible for a series of thefts at school and was brought before the Juvenile Court. When challenged about the thefts at school she produced a number of very plausible stories incriminating other children but these were easily disproved and it was found that she had often given away or thrown away the articles she had stolen. She was eventually placed on probation with the condition that she attend for psychiatric treatment. The psychiatrist who saw her considered that in addition to her behaviour problems she was mentally and emotionally retarded, probably as a result of an insidious psychosis and the child still attends the clinic as an out-patient.

Just before the age of two years Hazel had what appeared to be a febrile convulsion and a few weeks later she began to masturbate; whenever otherwise unoccupied she would sit wriggling and shuffling backwards and forwards becoming red in the face and excited and finally falling back at the climax. This behaviour at first occurred many times a day but gradually diminished in frequency and her parents believe that the habit stopped some time before she started school though she still frequently

rocks backward and forward in her chair.

The onset of the masturbation appeared to coincide with the development of quite severe constipation with faecal soiling, and at two and a half years this led to her admission to hospital for bowel washouts and investigations to exclude Hirschsprung's Disease. Despite intermittent treatment with laxatives the soiling continued until just before starting school and she still tends to be constipated.

Her developmental milestones were normal apart from a moderate dyslalia which responded to speech therapy at the age of six years. She settled quite well at school and until the age of about nine years was regarded as good average but since that time there has been a deterioration in her school work. Since she was nine years old she has been extremely reluctant to attend school and though she has never actually truanted, at times her mother has 'to drag her there'. Over the same period she has become an accomplished liar and no one ever knows when she is telling the truth. At home she is solitary and neither jealous of nor particularly attached to any of her siblings. Although she has a volatile temper, shouting, stamping her feet and throwing things when she is upset, she is normally quite obedient. Outside the home her parents regard her behaviour as normal but her schoolteachers consider her detached and unapproachable though, despite deterioration in her school work, not educationally sub normal. She had no serious illness

but had a febrile convulsion with an upper respiratory infection at two years and at two and a half years spent five days in hospital for investigation of constipation. This has been her only separation experience though her mother has worked part time in the evenings since Hazel was five years old.

Hazel's mother is a simple placid woman with variable domestic standards who seems unable to maintain discipline among the children. All the children seem to browbeat her into complying with their demands for money and irregular meals. Her husband was unemployed for the first four years of Hazel's life because he couldn't find a job 'with decent money'. He is frequently irritable and bad tempered often striking his wife with little provocation. In recent years he has worked regularly as a builder's labourer but seems prone to minor accidents which keep him off work 'on compensation' for substantial periods. His response to Hazel's recent activities has been to "give her the belt" and he believes he can cure all her troubles in this way.

19. DESTRUCTIVENESS

(1) Destroys own belongings and those of others, toys last less than a week. Often an apparently compulsive urge to destroy things but may be destructive only in a rage if this occurs more than twice a month.

(2) More destructive than average. Once or twice a month destroys property in rage.

3 Normally careless for age, has 'accidents', occasionally deliberately destructive.

4 Very careful of property. Cares for things but not so fussy that he cannot enjoy them.

(5) Excessive care and protection; almost of obsessional intensity. Cannot really enjoy himself for fear of damaging toys or dirtying clothes.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL. /CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	0	0	0	1	0
(2)	10	3	4	0	2	0
3	28	18	30	16	7	3
4	32	25	25	30	5	3
(5)	3	4	0	0	0	1
6	3	1	0	0	0	0

Controls as maladjusted
(1) & (2) only
$X^2 = 5.2$ $P < 0.05$
(1), (2), & (5)
$X^2 = 10.3$ $P < 0.01$

DESTRUCTIVENESS

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	17.1	6.0	12.7
Control group	6.8	NIL	3.8
Population Estimate	9.5	NIL	5.5

[Diff. = 1.83 times standard error]

Diff. = 2.33 times standard error

EXCESSIVE CARE

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	4.0	8.0	5.6
Control group	NIL	NIL	NIL
Population estimate	NIL	0.9	0.8

DESTRUCTIVENESS

Lewis (1954) found destructiveness as a symptom in 12% of her sample of deprived children from a Kent Reception Centre. Destructiveness is recorded by Ackerson (1931) in 7% of boys and 4% of girls but in the present study the symptom was a good deal more common, particularly among boys. Sixteen of the maladjusted group and four of the controls were recorded as destructive ($X^2 = 5.23$ $P < 0.05$).

Seven of the maladjusted group were recorded at the other end of the scale as showing almost obsessional care of property.

The symptom of destructiveness was commoner in boys (17.1%) than in girls (6%) in the maladjusted group though the difference is below the accepted level of significance. In the control group 6.8% of boys and no girls were included in the symptom categories and the population estimate is 9.5% for boys and nil for girls - a significant sex difference.

Intersymptom correlations were calculated combining ratings (1), (2), and (5) and were as follows:- 0.327 with quarrellsomeness, 0.242 with undue dependance on others, 0.218 with stealing, 0.214 with disobedience, and 0.200 with adventurousness. A notable absence is any correlation with temper display.

Illustrative Cases Jack M.

Jack has little, if any, sense of value and this is particularly evident in his destructiveness. Toys have always been objects to be torn apart as soon as possible and he is little better with his clothes which, apart from the numerous rents he acquired during his normal days activity, he often tears either in rage or because he has nothing else to interest him. His grannie, who has brought him up, keeps anything of value,beyond his reach and has a number of elaborate methods of achieving this. He displays the same disregard for other people's property but somehow escaped police notice until a time beyond the range of the present investigation.

His first known ventures into theft were at the age of four years when he began to steal 'bait tins' from parked lorries and since then, according to his grandmother, 'he takes anything he can lay his hands on and seems to think he has a right to them whether at home or outside'. He is a restless overactive lad who 'never walks when he can run' and at night he is a restless sleeper. It is always difficult to get him to bed and once there he seems to have difficulty in getting to sleep; during sleep he kicks off the bedclothes, often shouts and screams, has nightmares about once a month and has walked in his sleep a number of times.

Jack has an explosive temper, easily provoked and completely out of control, and he has attacked his grandmother, and visitors to

the house on a number of occasions, often using a poker as a weapon. Fortunately it has always been possible to restrain him but neither his grandmother nor neighbours who have been called to her assistance have ever sought help from the authorities.

He goes out of the house early each morning, often truants from school and in any case never returns home until late at night when he refuses to given any account of where he has been. His wandering from home began before he started school but apart from the fact that he is often seen in the vicinity of the city markets it is impossible to discover where he goes. At school he is taciturn, sullen, and retarded in his school work only coming to life during playtime when he is the terror of the playground. Both at school and at home he is an *inveterate* liar and completely devoid of emotional attachment to others although his grandmother, who now considers him far too independant, regarded him as clinging until he started school. He has a ravenous appetite but is extremely faddy and complaining about his food. His finger nails are always chewed to the extent of making his fingers sore and though he is generally overadventurous and fool-hardy he is afraid of the dark when in bed.

The boy has twice been in hospital; his first admission at the age of two months when he became dehydrated as a result of feeding mismanagement and diarrhoea, lasted nearly three weeks and the second shortly

before the age of two years was a stay of just over a week for a surgical repair of an inguinal hernia, on neither occasion was he visited. At the age of two years he attended a day nursery for several weeks but was withdrawn because his grandmother was unable to pay his fees.

Jack is the illegitimate son of a woman of limited intelligence who has several times escaped certification as a mental defective only because of the efforts made by her parents. For several years before Jack's birth when his mother was aged 25 years, she had been attending a local clinic for the treatment of venereal disease and was known to be a prostitute. She has never at any time accepted any real responsibility for the boy's care, leaving this entirely to her mother. Until the boy was five and a half years old she lived intermittently in the household, obtaining a succession of full time jobs, sometimes away from home but never staying in any of them for longer than three months. When at home she often took the boy to places of entertainment keeping him out till 11.00 p.m. and by the age of eighteen months he was a regular customer at the local Music Hall. When the boy was five and a half years old his mother became 'housekeeper' to an old client, to whom she now has several children, and has seen little of the boy since.

He has been brought up by his harsh, inconsistent grandmother who has always regarded him as yet another burden in her already overloaded life. She has two other daughters, one of whom has been in a mental

hospital for many years; the other is married and has a family but has made several suicidal attempts and appears to be of chronically unstable personality. Her only son lives at home but is unemployable following tuberculous meningitis in his late teens and her alcoholic husband fell downstairs and broke his neck when Jack was aged four years and eight months.

Illustrative Case (excess case)

This tense, fastidious boy has always been exceptionally careful about his personal appearance and care of his clothes and toys. He still has every toy that was ever given to him and each has its appointed place in his playroom. He plays very little with his toys and is unable to entertain himself though he has a few friends and prefers to spend most of his time at home. His rather obsessional mother potted him from birth and he has been 'clean' since before he could walk; as a toddler he would become extremely agitated if he so much as wet his shoe whilst passing water. Mother regards him as adventurous in his play and describes him as 'a bit of a daredevil' but he manages this without messing himself or his clothes.

Derek has dominated his parents since birth. He was a poor feeder as an infant and every method and formula of infant feeding was employed in an attempt to overcome this. When he was eighteen months old his parents took him on holiday for the first time but returned home within

a few days because 'he wouldn't settle'. He demanded constant attention and flew into a tantrum if he didn't get his own way. From the age of one year he 'wouldn't go to bed' until his parents settled for the night and during his third year he began to have frequent nightmares which still recur occasionally. Although for many years he has had a room of his own he refuses to sleep there always going to bed at the same time as his parents and shortly afterwards creeping into their bed. Feeding has remained a major problem. He always has to be forced to eat and up to the age of five years had intermittent episodes of food refusal lasting several days during which time he had to be spoon fed. At the age of four years he began to have recurrent attacks of abdominal pain at irregular intervals and no definite cause has ever been found for these attacks though his mother thinks they occur when he is worried about something.

When he was nearly four years old he was taken to a Dental Hospital in order to have some teeth extracted under anaesthesia but whilst a nurse was taking him to the theatre he bolted from the building and was only found and taken home after an extensive search of the area. Since this episode he has been terrified of doctors and hospitals and this fear, his tantrums and his general exitability led to his referal to a Childrens Out Patient Department. The paediatrician felt that the boy needed psychiatric treatment but for a variety of reasons this was

not arranged and the boy continued to attend the clinic at intervals of three to four weeks for a year.

He then started school and appeared to settle quite well but his problems continued, his nightmares recurred, he developed a transient slutter, began to be excessively restless and began an eye blinking habit with facial grimmacing. Until the age of nine years he would wet the bed three or four times a year becoming very distressed and ashamed when this occurred. His younger brother was born when he was nine years old and apart from a little jealousy, the only obvious effect was that he became less dependant emotionally upon his mother, though he still requires some support from her and prefers her to help him with routine tasks such as dressing himself. He still has to be forced to eat, has temper tantrums when frustrated and is excessively attention demanding but the most striking development in his behaviour pattern in recent years has been the exhibition of numerous fears. Apart from transient fear s which he commonly experiences he is still afraid of doctors, nurses, and hospitals, of the dark and of sleeping alone, he is terrified of getting water in his ears in case he goes deaf and is sometimes afraid that he will become blind.

Derek has had no serious illness though like his brother, he had eczema as an infant and he still gets recurrent abdominal apain. He was entirely left handed but his school and his father have taught him

to use his right hand. His only separation experiences were of one week at two years and two weeks at ten years when he stayed with his grandmother whilst his mother was in hospital.

Derek's mother is a fussy, overanxious, and obsessional womam who has smothered the boy with attention since birth. She is constantly preoccupied with her worries, usually centred upon the children, but maintains excellent physical standards in the home. Her husband is a small shopkeeper who runs a successful businesswith considerable drive. He tolerates his wife's anxieties reasonably well but his reassurence is to some extent self protective. His relationship with Derek is not a close one but he appears to be fond of the boy.

20. SHARING

(1) Strong resentment to sharing.

(2) Shares only under pressure.

3 Shares normally, often reluctantly.

4 Shares spontaneously, enjoys sharing.

(5) Excessive generosity, gives without consideration.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	1	0	0	0	0
(2)	10	4	3	3	3	0
3	45	25	34	28	7	2
4	13	15	20	12	4	2
(5)	5	4	2	3	1	3
6	1	0	0	0	0	0

Control as maladjusted
(1) & (2) only
$x^2 = 4.0$ $P<0.05$
(1), (2), & (5)
$x^2 = 4.34$ $P<0.05$

RESENTS SHARING

	BOYS%	GIRLS%	TOTAL %
Maladjusted Gp	17.1	10.0	14.3
Control group	5.1	6.5	5.7
Population Est.	8.1	5.7	7.1

EXCESSIVE GENEROSITY

	BOYS%	GIRLS%	TOTAL%
Maladjusted Gp	6.6	8.0	7.1
Control group	3.4	6.5	4.8
Population Est.	4.1	11.3	7.1

SHARING

Although some degree of reluctance to share is a social norm in children only four children, all from the maladjusted group, were recorded as showing the extreme range of this symptom. In all, eighteen children in the maladjusted group and six in the control group were in the symptom categories ($X^2 = 4.0$ $P < 0.05$). Nine children (7.1%) in the maladjusted group and five (4.8%) of the controls were regarded as excessively generous.

On the whole, reluctance to share is more common among boys (17.1%) than girls (10%) in the maladjusted group but none of the sex differences within this symptom range are statistically significant. In the control group 5.1% of boys and 6.5% of girls were in the reluctant categories and the population estimate is 8.1% for boys and 5.7% for girls.

Excessive generosity was recorded in 6.6% of boys and 8.0% of girls in the maladjusted group and 3.4% of boys and 6.5% of girls in the control group. The population estimate is 4.1% for boys and 11.3% for girls.

Intersymptom correlations were calculated for both groups combined and were 0.312 with quarrelling, 0.290 with emotional dependence, 0.284 with stealing, 0.229 physical timidity, 0.199 with depressive moods, 0.194 with lying, and 0.188 with jealousy.

Illustrative Cases

Stanley is the youngest of a family of five and the only boy, his youngest sister being two years older than he is. As a result he was much pampered as a baby and has always been described as 'spoiled'.

He has always been very possessive, he is very carefull with clothes and toys and resents anyone else handling them. As his sisters have married he has acquired nephews and neices but will never allow them to handle any of his toys even things he has grown out of and he is reluctant to give them "gifts" although these are in fact supplied by his parents. With his own companions, he adopts the same attitude and will never, unless compelled share even a bag of sweets.

His reluctance to share was also evident in his toilet training which was a constant battle. He vigourously resisted the potty and defaecated indiscriminately about the house until he was over three years old; continued to wet his trousers until the age of five years, and wet his bed regularly until aged seven years. At the age of three and a half years he began to stammer and though this gradually became less evident he still has a marked hesitation in speech when excited. As a toddler he was extremely aggressive towards other children but since starting school has gone to the other extreme, refusing to quarrel with other children or to defend himself.

On starting school he became very disturbed and fearful and for over a year had to be accompanied to and from school and visited at the school by his mother at playtime. He is extremely dependant upon his mother who can never go out without him and has to give him a good deal of support in most of his activities. His appetite is very poor and he is extremely faddy, though he is inconsistent in his likes and dislikes. At play he is fairly adventurous if someone else is prepared to lead but he is acutely afraid of the dark and of being left alone in the house.

A poor mixer, he is extremely shy with both adults and children, and he has few friends, prefering to play on his own. At home, he is moderately obedient but inclined to be bad tempered, usually sulking when he has been upset. He is very modest, refusing to undress in front of his parents and becoming panicky if seen in his underclothes. At night he is restless and has nightmares at least once a month. Although there is no difficulty now in getting him to school he is often anxious about school situations despite his consistently good reports. His parents were disappointed when he did not obtain a place in a Grammar School and he is very much aware of having 'failed' his grading examination.

Stanley has had no serious illness and his only separation experience was at the age of ten years when his mother was away for two weeks visiting relatives.

His mother is a quiet, matter of fact woman who copes very well with her home and is obviously fond of the boy. She is reluctant to discuss her feelings but admits that her marriage is unhappy though she glosses over her marital difficulties.

Her husband works as a lorry driver but is a heavy drinker and has had several spells of unemployment. When drunk he is often violent towards his wife and for several years they have slept in seperate rooms. He spends little time at home and has never really established a satisfactory relationship with his son.

Illustrative Case

Eric is regarded by his parents as 'generous to a fault', he is forever giving his things away, and will sometimes give away a toy within a few hours of receiving it. He is aware of the value of the things he dispenses but when chastised by his parents for his excessive generosity can never explain why he does it.

The boy has presented a series of problems since infancy. He started life as a feeding problem and as a toddler became very bossy and aggressive, kicking and biting other children without provocation. At the age of three he was admitted to hospital for tonsillectomy and although only kept in overnight after the operation, he was very distressed by this experience. Following this incident he became timid and shy, wouldn't play with other children, became terrified of strangers and even relatives outside the immediate household, and developed

a marked stutter.

Later in the year he began to have nightmares, waking up nightly shouting and screaming in a state of terror and at the age of six years he began to walk in his sleep. Since the age of nine his nightmares have gradually ceased but he is still restless at night, often moaning and talking in his sleep and always reluctant to go to bed. By day he is generally overactive and boistrous.

He has disliked school from the beginning and often has literally to be dragged there. He seems to fear going to school but once there settles fairly well. For several years he complained of abdominal pain every morning saying 'I've got my pain, I can't go to school', but since the age of nine he only gets the pain when there is to be some activity at school which he particularly dislikes, such as a class examination. Although his mother now ignores this pain it did cause considerable anxiety in earlier years. His appetite is good but he is extremely faddy, refusing all vegetables, and subject to whims and fancies regarding other items of diet. He is still over-dependant on his mother, clinging to her a good deal and trailing round behind her; if mother goes out without him he sits on the stairs or by the window worrying in case she does not return.

His main difficulties appear to be in relations with his peers and this seems to be an important factor in his dislike to school. He is very shy with other children and extremely modest about his

person; he is terrified of being seen undressed and refuses to use the showers at school. His playmates are invariably young or handicapped children, described by his mother as 'lame ducks'. He has no real friends, and attended for only three weeks when he joined the cubs. It is easy to upset him and he is particularly sensitive to ridicule or 'being called names'.

Since the age of nine and a half years this pattern of behaviour including his stutter, has continued but there has been a change in his attitudes towards adults. Instead of his shyness he is now rather brash and cheeky and has become extremely defiant and evasive at home. His father, who has always regarded him as a problem child, insists in the boys presence that unless his behaviour improves he will have to 'be put in a home'.

Eric has a brother two years older than himself and there is some jealousy and quarrelling between the boys. Their main rivalry is for their grandmother's affection and for many years they have each spent alternate weekends at her home - "she can't stand them both together". Apart from these weekends he has only been separated from both parents on two occasions, his overnight stay in hospital at three years, and a few days in hospital at ten and a half years for the removal of nasal polypi. His father worked away from home intermittently during his first six years of life but was never away for more than three consecutive weeks. Apart from recurrent upper respiratory

infections which caused little disability he has had no illness of consequence. He is left handed but has always been made to use his right hand.

His mother is a capable but limited girl who is genuinely perplexed by Eric's behaviour and is rather inconsistent in handling him. Father is usually employed as a lorry driver but has an unstable job record, having had five jobs in ten years with about a month of unemployment between each. Although he is said to be interested only in his home and family he is frequently at loggerheads with Eric and they have little affection for each other.

21. QUARRELLING

(1) Constant quarrelling, 'chips on the shoulder.' Starts quarrels with little or no provocation.

(2) More quarrelsome than average but not as consistent as (1).

3 Quarrels with provocation, sometimes starts them.

4 Less quarrelling than average.

(5) Refuses to quarrel either by withdrawal or extreme placation. Disturbed at any sign of friction.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	0	0	0	0
(2)	9	7	2	0	3	0
3	31	21	36	27	3	2
4	27	17	20	18	8	4
(5)	7	4	1	1	1	1
6	6	1	0	0	1	0

Mal. as Controls
(1) & (2)
$X^2 = 10.9$ $P < 0.001$
(1), (2) and (3)
$X^2 = 15.9$ $P < 0.001$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	14.5	14.0	14.3
Control group	3.4	NIL	1.9
Population Est.	6.8	NIL	3.9

Diff. = 1.96 times standard error.

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	9.2	8.0	8.7
Control group	1.7	2.2	1.9
Population Est.	2.7	3.8	3.2

QUARRELLING

Quarrelsomeness was reported by Ackerson (1931) in 12% of both boys and girls in his group. Craig (1956) found overt aggression a problem in 27 of the 200 children he studied, all of whom had been seen in a Paediatric Out Patient clinic because of behaviour difficulties. Lewis (1954) considered 11% of her sample of deprived children to be quarrelsome.

In the present study eleven (14.5%) boys and seven (14%) girls in the maladjusted group were regarded as quarrelsome. None of the girls and only two boys (3.4% of boys or 1.9% of the total group) from the control group were so regarded ($X^2 = 10.9$ $P < 0.001$). The population estimate for this symptom is 6.8% of boys and no girls affected, a difference which is statistically significant.

On the other hand 3% of boys and 0.4% of girls in Ackerson's study were reluctant to defend themselves and sought to avoid friction. This symptom was much commoner in the present study, comprising 9.2% of boys and 8% of girls in the maladjusted group. In the control group the sex incidence was reversed 1.7% of boys and 2.2% of girls came into this category whilst the population estimate showed a similar tred, 2.7% of boys and 3.8% of girls.

In the calculation of intersymptom correlations both ends of

the scale were combined and the correlations were 0.327 with destructiveness, 0.312 with problems of sharing, 0.263 with physical timidity, 0.251 with irritability, 0.250 with emotional dependance, 0.229 with undue sensitivity, 0.216 with instability of mood, 0.208 with stealing, 0.189 with attention demanding, and 0.174 with depression or sadness.

Illustrative cases.

Since the age of three years Leslie is said to have been 'the terror of the neighbourhood' fighting anyone, regardless of size, on the slightest pretext and seeking to dominate any group he joins. He has no real friends but forces himself on to other children usually bringing about a rapid disintegration of the group through his aggressive behaviour. Despite his marked desire to be top dog he is in some ways shy, he is reluctant to go into other people's houses or to parties but once there is soon showing off.

He has wet his bed regularly since infancy, though he has occasional dry spells which may last several weeks, and he is intermittently wet during the day. Since the age of seven years he has soiled his trousers several times a week. At first he was very shamefaced about this and would try to wash his underwear but he is now apparently unconcerned by this symptom.

Up to the age of four years he was an habitual thumb sucker but he weaned himself quite abruptly. He has always been restless at night, talking in his sleep and kicking off the bedclothes, and during

the day displays a boundless, restless energy, and 'he can't sit still for a minute'. When he is unoccupied, he chews his coat lapels, tie, or pullover in a highly destructive manner. He is rough on clothes generally and is always dirty and unkempt in appearance unless carefully supervised. With toys and other personal possessions he is very careful and tidy, enjoys playing with them but strongly resents having to share anything. On a number of occasions he has been accused by neighbours of stealing toys or money from other children but this has never been proved.

According to his mother he is a 'famous liar' telling utterly fantastic stories to the point that no one can ever believe what he says. At home he is wilful, disobedient, moody, and has a vile temper with frequent tantrums during which he screams and punches whoever has offended him. His appetite is described as gluttonous despite numerous food fads. Despite his apparent boldness he is afraid of the dark and of noises in the night and is over-dependant on his mother who says "he hangs round me like a shadow, always wanting me to cuddle and fuss him. I sometimes think he doesn't feel so secure as he tries to think he is." He is very jealous of his only sibling, a sister two years older than himself, and he is often aggressive towards her.

He has always disliked school and is a poor scholar, he has had particular difficulty with reading and spelling, and even now can hardly read. His speech has always been defective and though he has had speech therapy since the age of three and a half years he still makes consonant substitution.

When Leslie was six months old his mother took up full time work as a shop assistant and he attended a day nursery, continuing there until he started school. At the age of four years he spent two days in hospital for removal of his tonsils and adenoids but had no serious illness until he was eight years old when he developed acute appendicitis. His appendix ruptured and he was admitted to hospital with an abscess and spreading peritonitis. After three weeks in hospital he was discharged to a convalescent home for a further month. Three months later he was readmitted for appendicectomy and after three weeks was sent for a further six weeks convalescence.

Leslie's mother is a chronic neurotic, who, despite a plausible veneer, is an inadequate mother and housewife. She had little affection for the children and is extremely erratiw inher handling of them. Her husband is a shadowy figure in the background; he works regularly as a galvaniser but takes no interest in his home or family. He rarely initiates a conversation and according to his wife 'he can go for days without speaking because he's content to sleep all the

time he's in the house.' Once installed in his armchair he can sleep comfortably through any family disturbance and he is timid and reserved when awake - 'he's liable to be sick if you do have a row with him.'

Illustrative case

Victor is a shy, timid boy who is afraid of friction or violence He allows other children to bully him or take his possessions from him without attempting to defend himself. Even when not directly involved, he shrinks from quarrelling and will leave any group in which a squabble develops.

He has always been a sad, doleful looking little boy and as early as his second year his mother complained that he never showed any spirit. Since the age of a year he has been extremely shy and afraid of strangers. Although since starting school he has stopped running away or hiding his face when strangers approach, he remains shy and fearful. At birth he had two elder brothers under the age of five years and his mother was rather overwhelmed and depressed by this trio during his first year, the more so towards the end of the year when she found herself pregnant again. When his mother went into hospital for delivery, Victor spent three weeks in a residential nursery and on his return home began to have frequent and violent temper tantrums.

The new infant proved to have congenital heart disease and died within the first few days of life. Mother even more despirited and depressed, found Victor's tantrums difficult to cope with and her mental state worsened when she quickly became pregnant once more. At two and three months Victor again spent two weeks in a residential nursery whilst his mother was delivered and on discharge his behaviour had markedly deteriorated. He was sullenand resentful towards his mother, jealous of his new baby sister, pulling at mother when she nursed the infant and having surreptitious digs at the baby whenever possible. His speech which had developed slowly and with a moderate dyslalia became almost unintelligible, his toilet training regressed and he had to be put back into nappies. His temper tantrums became worse.

Although his behaviour improved a little in subsequent months he was very dependant upon his mother, becoming agitated if she was out of his sight for a few minutes. He refused to play outside with other children and on the one occasion he did venture out alone, the first time for several months, he took with him four pound notes from his mother's purse and lost them.

His overdependance on mother, shyness, fear of strangers, and refusal to play outside his own garden continued and when he started school his 'nervousness' increased. For several months it was difficult

to get him to school and there was a scene each day as preparations were made to take him there. He developed a marked facial tic but eventually appeared to settle at school and was prepared to go unaccompanied though his dislike remained. At the age of six years he spent threee days in hospital whilst his tonsils were removed and on return to school he ran away several times and was usually found hiding, somewhere near his home, in a state of terror, crying 'don't send me to school.' Enquiry at school failed to elicit any specific cause for his anxiety though his head teacher remarked that he was an odd boy without any friends there.

After these incidents he was referred to a psychiatrist who saw him on a number of accasions though no specific diagnosis was made and psychometric testing indicated a good average intelligence. His dislike to school has persisted and he remains vaguely afraid of going there but has continued to attend and his progress is considered satisfactory. His speech improved with therapy but he still has difficulty in pronouncing S and F.

His facial tic seemed to settle at about the age of eight years but recurred when he was ten years old and is now mainly eye blinking. He bites his nails 'to the quick', is still shy and timid, and though he is now regarded as fairly independant, he still requires some support and is generally fearful and apprehensive. Even when with his brothers

he is afraid to go more than a short distance from his home, though he will travel into town if accompanied by his mother. He is inclined to be restless, is destructive with toys and clothes, and still has to be persuaded to play outside, he has few friends and usually plays alone.

Victor's mother is a timid anxious woman who suffers from chronic neurotic depression but copes reasonably well with the physical aspects of the household. His father is a sullen, solitary man who works long hours on an open cast coal site and, according to his wife, hardly ever sees the children and is never very interested in them when he does see them. He has been under treatment from his G.P. for several years for 'nervous depression due to overwork'. Mother resents her husbands lack of interest in the children and herself and this leads to frequent quarrels in the home.

The three separations already mentioned are his total separation experience and he has had no serious illness.

22. EMOTIONAL DEPENDENCE.

(1) Extreme emotional dependence upon parents or other adults. Constantly seeking support or reassurance, extreme overactivity to parents moods —— parent fixation.

(2) More dependant and emotionally tied than average though less extreme than (1); dependant but has some emotional values not tied up with parents.

3 Emotional give and take, dependant in some respects.

4 Accepts parents as persons, fairly independant.

(5) Aggressively independent, cut off from any close emotional attachments or so narcissistic that he is incapable of close attachments.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	6	6	0	3	2	1
(2)	20	9	11	5	6	3
3	11	12	14	14	3	1
4	30	19	31	24	2	2
(5)	9	5	3	0	2	0
6	9	4	0	1	0	0

Mal. as Controls
(1) & (2)
$X^2 = 7.49$
(1), (2) & (5)
$X^2 = 11.96$

DEPENDENCE

	Boys%	GIRLS%	TOTAL%
Maladjusted group	34.2	30.0	32.5
Control Gp	18.6	17.4	18.1
Pop.Estimate	25.7	22.6	24.4

INDEPENDENCE

	BOYS%	GIRLS%	TOTAL%	
Maladjusted group	11.8	10.0	11.1	
Control gp	5.1	NIL	2.9	
Pop.estimate	6.8	NIL	3.9	*

* Diff. = 1.96 times standard error

EMOTIONAL DEPENDANCE

Although Ackerson (1931) found 'overdependance' in only 3% of boys and one per cent of girls this symptom was much more common in the present study. Abnormal degrees of emotional dependance were found in 41 (32.5%) of the maladjusted group and 19 (18.1%) of the controls ($X^2 = 7.5$ $P < 0.01$) and the symptom occurred with almost equal frequency in both sexes.

The population estimate for this symptom is 25.6% of boys and 22.6% of girls giving an overall incidence of 24.4%.

Extreme independance was seen in nine boys (11.8%) and five girls (10%) in the maladjusted group but only in three boys of the control group. The population estimate for extreme independance is 6.8% of boys and no girls, an overall percentage of 3.9; here the sex difference is significant.

Intersymptom correlations, calculated with both symptoms combined, were as follows 0.358 with excessive reserve, 0.329 with depression or sadness, 0.321 with temper, 0.315 with lack of self reliance, 0.305 with shyness, 0.290 with reluctance to share, 0.256 with food fads, 0.252 with physical timidity, 0.250 with nocutrnal enuresis, quarrelling and attention demanding, 0.240 with disobedience, 0.232 with noctural restlessness, 0.215 with fears, 0.198 with restless overactivity, 0.176 with irritability, and 0.172 with inadequate appetite.

Illustrative Cases

Greta is a shy, timid girl who is extremely dependant upon her mother and maternal grandmother. She is unwilling to make any decisions, needs support and encouragement in the performance of the simplest of tasks and becomes upset if her mother or grandmother are not immediately available when she wants them. When with her mother she is very demonstrative and insistent in her affection and though she is shy at first with strangers she must always be the centre of attraction.

Since infancy she has been described as spoilt and she has always been jealous of her three younger siblings, two brothers and a sister, the eldest of whom was born when Greta was two years old. She has always been a pert, doll like child whose timidity and shyness have a histrionic quality. Always careful with her toys and clothes she takes considerable pride in her appearance and takes care to avoid dirtying herself or her clothes when playing. Her mood is usually cheerful but she is easily upset and extremely sensitive, particularly to implied criticism from her mother or grandmother. At home she is unusually abidable (obedient), fidgetty by day and restless at night, and has difficulty in occupying herself in play. Outside she is timid and placid, allows other children 'to put upon her', avoids any friction, and has no real friends.

For several years she has had bouts of abdominal pain which occur every two to three weeks and last for three or four days. During these attacks she is usually confined to the house but her family doctor has told her mother that the attacks are bilious and require no treatment. Apart from occasional headache and 'penicillin sensitivity' she has had no other illness. She has been separated from both parents on only one occasion when at the age of six years she spent three days in hospital following tonsillectomy. Her father did not join the household until she was six months old and until she was $2\frac{1}{2}$ years old he worked away and was at home only for weekends.

When Greta was born her father was serving overseas in the Navy and her parents were not married until she was six months old. Her mother is an anxious immature woman who has suffered from 'nervous debility' since childhood and is, in turn, very dependant upon her own mother. For the first seven years of Greta's life the family lived in with the maternal grandmother but when they obtained a house of their own the maternal grandmother and her other daughter moved there with them. With considerable support from grandmother, this mother maintains reasonable standards in the home but it seems likely that without such support her standards would fall.

The girl's father is a somewhat negative character who seems to be completely dominated by the women of the household. He does,

however, work regularly and is fond the children.

Illustrative Case

Ian is a small boy who is aggressively independant and seems incapable of forming an affectionate relationship with anyone. He treats his parents and two younger sisters as casual acquaintances and resents any attempt to give him help or affection. Since he was a toddler he has refused to go out with his parents and seems generally to prefer his own company. In recent years he has acquired a large and everchanging group of companions but has no real friends.

From the age of two years he has had a spectacular succession of accidents, mostly falls resulting in minor lacerations though he has had two or three fractures. He is on christian name terms with the staff of the local accident hospital and at the age of eight years could boast that he had been stitched in forty places. His accident proneness seems to be decreasing and no incidents have been reported in the past year. At the age of two and a half years and again at three years and seven months he had what appeared to be major febrile convulsions and it is tempting to relate his accidents to epileptic attacks. However, the accidents appear to have occurred in a state of clear consciousness and are more probably related to his general foolhardiness. He is extremely rash in his activities and has the reputation that he will try anything once.

At the age of seven he began to soil his trousers and this symptom continued almost daily until the age of nine when it gradually disappeared over the course of a few weeks. For the past two years he has been a persistent wonderer vanishing several times a week and not reappearing until late evening or early hours of the morning. During the same period he has truanted intermittently from school but his parents are often unaware that he has done so, and, in any case, are little concerned by the truanting. He is a moody, quick tempered boy, invariably negatistic and defiant to his mother but moderately obedient for his father.

Ian was a premature baby with a birth weight of four and a half pounds but thrived quite well until the age of three months when he developed gastro-enteritis and was admitted to hospital. After ten days in hospital he returned home but four days later a recurrence of symptoms led to his readmission and he spent a further two weeks in hospital. Since this time he has had no illnesses other than those occasioned by his accidents.

The family lived in with the maternal grandparents until Ian was seven years old when they moved into a two roomed flat in a pre war block of municipal flats. Ian however remained with his grandparents for six months before joining the rest of the family. His father has deserted the family on two occasions, the first when Ian was one year

old and the second when he was four years old, but on each occasion the father returned after an absence of one month.

Ian's mother is a tense, anxious and inadequate individual who has been in full time employment since the boy was four weeks old. She is unable to cope with the small flat which is always dirty and untidy, standards of personal cleanliness in the home are low and the family are poorly fed. Father is a shiftless individual who drifts from one labouring job to another, interested only in 'the dogs', and 'a good time'. Both parents are moderately heavy drinkers and frequently they are out separately at night leaving the children alone in the house.

23. LACK OF SELF-RELIANCE

(1) Insists on help with simple routine tasks.

(2) Prefers help with simple tasks. Slow and uncertain if left to himself. (Includes those instances where child's preference is irrelevant and mother assists with even simplest tasks).

3 Accepts help but can manage alone.

4 Never asks for help.

5 Vigorously refuses help in any task.

6 Previous symptoms..

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	0	1	1	0
(2)	16	6	4	2	5	3
3	37	33	35	37	7	4
4	19	8	18	5	1	0
5	2	3	2	1	1	0
6	0	0	0	0	0	0

Mal. as Controls
$X^2 = 6.6$ $P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	23.7	12.0	19.1
Control group	6.8	6.5	6.7
Population estimate	13.5	11.3	12.6

(Diff. = 1.64 times standard error)

LACK OF SELF RELIANCE

Undue reliance on others was found in 24 (19.1%) of the maladjusted group and 7 (6.7%) of the controls ($X^2 = 6.6$ $P < 0.01$). In the maladjusted group the symptom was commoner in boys (23.7%) than girls (12.0%) but the difference is not statistically significant. No such difference was evident in the control group nor in the population estimate which is 13.5% of boys and 11.3% of girls.

Intersymptom correlations were 0.315 with emotional dependance, 0.279 with wondering, 0.243 with temper, 0.242 with destuctiveness, 0.238 with disobedience, 0.234 with shyness, and 0.205 with food fads.

Illustrative Case

Richard, at the age of eleven, is still washed and dressed by his mother each morning before going to school. He will never do anything for himself if he can persuade his mother to do it for him, and after she has sugared his tea he will push it aside complaining that it hasn't been stirred.

He has dominated his mother from the age of ten months when he would not settle to sleep before midnight, refused solid foods, insisting on frequent breast feeds and his mother was severely handicapped in her housework, because she 'daren't go out of his sight

for fear he raises the roof' By the age of one year he was following mother around the house and making her sit down to feed him 'every ten minutes' whilst during the night he slept in her bed and continued his frequent short feeds. After a variety of techniques, including the application to the breast of bitter aloes, weaning was achieved at thirteen months and the boy settled down to a long succession of food fads.

His toilet training was a long and unsuccessful battle so far as his mother was concerned. She started potting early but usually missed her cues and regarded the baby as defiant. By the time Richard could toddle he was refusing his potty and would defaecate as his mother chased him about the house. Surprisingly enough just after the age of two years he began to seek out the potty himself and has been clean and dry since.

At the age of eighteen months he wandered away from home and was found by a relative in a nearby busy shopping centre. From that time he was missing from home several times a week and on a number of occasions he was reported to the police as missing from home, the last occasion being at the age of nine and a half when he was missing for thirteen hours. Since this last episode his wandering has become more socially integrated, and he now goes camping or hiking with a companion, or on long solitary cycle rides but gives notice of his intentions.

He is an accomplished liar, frequently romancing about his merits at school or his prowess at fighting and can lie his way out of most troubles. His concentration is poor, he is extremely restless and overactive at home and at school where his attainment is average. His sense of the value of property is poorly developed and he is inclined to be destructive. He occasionally takes money from his mother's purse in addition to the four or five shillings per day he extracts from her. Until the age of six years he had frequent tantrums but is now merely 'sharp tempered', shouting and crying when in a rage. He is invariably defiant and disobedient to his mother whilst with strangers, he is rather less inhibited than most children. Recently he has become very modest at home, refusing to undress in front of his mother.

Richard has had no serious illness and has never been separated from his mother, though she spends a good deal of time at her work. She owns a small lock-up general dealers shop which is the social centre of a poor neighbourhood. The shop was left to her by her own mother who died a year before Richard was born. His mother reluctantly left the day to day running of the shop to relatives until Richard was eighteen months old when she resumed control. She served in the shop

from 9 a.m. to 10 p.m. whilst Richard was left in the care of a succession of relatives.

Mother is a curiously feckless girl who devotes all her energy to managing her back street shop, apparently successfully. She has poor standards in her own home which, despite the smart car at the door, is untidy, uncomfortable, and often dirty. Her care and supervision of her only son is grossly inadequate and whilst in many respectsoverindulged he is evidently lacking in security and affection.

Richard's father is a bus conductor, a pleasant young man who worked regularly and shared domestic chores with his wife. He looked after the baby one night every week whilst his wife went dancing and his mother would baby sit another night in order to allow him to take his wife to a cinema. When his wife returned to work in her shop he found himself seeing little of her or the child, Richard being brought home from whichever relative happened to be caring for him after 10 p.m. and put straight to bed. There may well have been other factors concerned but father's increasing resentment against his wife's long hours of work outside the home led to increasing friction. When Richard was five years old his father left the house and went to live with a woman in a distant town and now has two children to this woman. He makes no attempt to keep in touch with his son.

24. SHYNESS

(1) Exceptionally shy; panic withdrawal or antagonism in social situations. Avoids meeting people, won't look at them, hangs head, etc.

(2) Shy, easily embarrassed, anxious in social contacts, shy even with people he knows.

3 Not shy with people he know.

4 Characteristically at ease in social situations.

5 Exceptional absence of shyness.

6 Previous symptoms.

CATEGORY	Maladjusted		Control		Mal./Cont.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	5	2	0	0	0	1
(2)	18	15	9	3	4	2
3	33	20	35	28	7	1
4	10	11	15	13	2	3
5	10	2	0	2	2	0
6	11	7	0	1	0	1

Mal. as Controls
$x^2 = 12.5$ $P < 0.001$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	30.2	34.0	31.7
Control group	15.3	6.5	11.4
Population estimate	17.6	11.3	15.0

SHYNESS

Marked shyness or bashfullness was recorded in 14% of boys and 16% of girls in Ackerson's (1931) series.

Extreme shyness, category (1) in this study, was seen in seven of the maladjusted group and in none of the controls, whilst lesser degrees of abnormal shyness were seen in thirty three of the maladjusted and twelve of the controls ($X^2_c = 12.5$ $P < 0.001$).

Whilst the symptom occured with almost equal frequency among boys (30.2%) and girls (34%) in the maladjusted group it was seen more commonly in boys (15.3%) than girls (6.5%) in the control group; the difference however is not statistically significant. The population estimate is 17.6% for boys and 11.3% for girls.

The intersymptom correlations were 0.338 with excessive reserve, 0.318 with fears, 0.305 with emotional dependance, 0.267 with sadness or depression, 0.234 with lack of self reliance, 0.228 with food fads, 0.226 with physical timidity, 0.191 with undue sensitivity, and 0.185 with faecal soiling.

Illustrative Case

The daughter of a young vivacious Italian girl, Maureen has always been large, gawky and mentally slow. Her parents married whilst her father was serving in Italy after the war and her mother

arrived in this country at the age of eighteen years, pregnant and apprehensive, to discover that her husband was a widower with two children and a crippled mentally defective brother. They lived with the paternal grandparents during the pregnancy and until Maureen was nine months old, and throughout, the 'stigma' of her husband's mentally defective brother preyed on this mother's mind. She was worried that her own infant might be defective and was fiercely over-protective from the beginning. It was against this background that Maureen's intense shyness developed.

According to her mother Maurreen would never permit strangers to handle her as an infant, as a todder she would run away and hide if a stranger approached, and now this tall, awkward girl will stand mute if confronted by a stranger and bolt for her room at the first opportunity. She is a solitary child and though she has a few occasional playmates, she avoids other children whenever possible. Nothin g will persuade her to attend parties or other social functions and she attends school with great reluctance.

Her development has been slow throughout. She didn't begin to take her first steps until the age of two years and at that time could only say 'mamma' and 'dadda'. She had always been slow to learn and since starting school has been regarded as backward. It is only in recent months that her mother has accepted that Maureen is 'backward

and difficult to handle.' Nevertheless the child remains in a secondary modern school and her mother will not seek advice concerning her scholastic failure because she 'wants to remain independant'.

The first troubles in Maureen's stormy development began with her toilet training. Her mother was an early and persistent trainer but the infant screamed and stiffened whenever applied to the potty and was three years old before daytime nappies could be discarded; she still wets her bed several nights a week. At about the age of three years she began to have night terrors and these occurred frequently for several years, then gradually disappeared. During the same period she became increasingly irritable and bad tempered having frequent temper tantrums. She still has daily tantrums in which she shouts, screams, kicks, and 'becomes quite hysterical'.

She has always disliked school and for her first two years was taken there in tears each day by her mother. On a number of occasions she has truanted and still has periods when she has to be forced to school. Her teachers regard her as backward but although psychometric tests have been carried out by the School Medical Officer she has not been ascertained as E.S.N.

Since infancy, she has had a huge appetite and now eats more than her father. She has boundless energy and is unable to sit still unless she is exhausted. Although considered fairly independant she

is very attached to her mother and resents her mother going anywhere without her. She is afraid of the dark and of going to bed alone, and she is jealous of anyone who receives attention from her mother. Her finger nails are well chewed and she still sucks her thumb at night, until the age of nine years her thumb having been in her mouth most of the day as well.

Maureen's mother is an attractive, aggressively independant and unhappy young woman who wanted to have a large family, but for reasons which she is unwilling to verbalise has felt unable to do so. She has found life in England not entirely to her liking and feels rather suspicious towards her neighbours who regard her as a foreigner. The responsibility of bringing up her own child and two step-children aged ten years and nine years when she married was a great strain to her in the first few years and she felt that she had little support from her husband. Her relations with her step children were always poor and the eldest boy left home as soon as he could. She maintains very high domestic standards and her home has the appearance of an unoccupied showpiece.

Her husband is a quiet but stubborn man who has worked regularly first as a clerk and later as a factory security officer. He has never had a close relationship with Maureen who is afraid of him and it seems likely that this is largely due to his wife's early and intense overprotection of the child.

25. TIMIDITY - ADVENTUROUSNESS.

(1) Extreme fearfulness or apprehension of new situations, sees risks and dangers in everyday situations.

(2) More cautious than average; may approach new situations if others try first but remains tense.

3 Normally cautious, possibly overcautious in specific situations.

4 Adventurous but not foolhardy. Takes and enjoys more chances than average child.

(5) Foolhardy, ignores real danger — may be compensating for fears.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	6	5	1	1	0	2
(2)	19	13	9	7	3	2
3	19	21	24	25	4	2
4	17	7	23	13	3	1
(5)	15	3	2	0	5	0
6	3	1	0	0	0	0

Mal.as Cont.
(1) & (2)
$X^2 = 12.1$
(1), (2) & (5)
$X^2 = 20.9$
$P < 0.001$

TIMIDITY

	BOYS%	GIRLS%	TOTAL%	
Mal. Group	32.9	36.0	34.1	*
Control group	17.0	17.4	17.1	
Population est.	17.6	22.6	19.7	/

OVER-ADVENTUROUSNESS

	BOYRS%	GIRLS%	TOTAL%	
MaladjustedGp	19.7	6.0	14.3	*
Control group	3.4	NIL	1.9	
Population est.	9.5	NIL	3.9	/

* Diff. = 2.2 times standard error

/ Diff. = 2.3 times standard error

TIMIDITY - ADVENTUROUSNESS

Twenty eight per cent of a sample group of deprived children studied by Lewis (1954) were regarded as showing undue timidity. Ackerman (1931) recorded "apprehensiveness" in 14% of boys and 12% of girls.

In this study forty three (34.1%) children in the maladjusted group and eighteen (17.1%) of the controls were included in the problem group for timidity ($X^2 = 12.1$ $P < 0.001$). There was no significant difference between the sexes in the incidence of this symptom and the population estimate is 17.6% of boys and 22.6% of girls.

Overadventurousness or foolhardiness was recorded in eighteen (14.3%) of the maladjusted group and two (1.9%) of the control group. In the maladjusted group fifteen (19.7%) of boys were affected as against three (6%) of girls. In the control group only two boys (3.4% of boys or 1.9% of the group) were affected whilst the population estimate is 9.5% of boys and no girls. The sex differences in both the control group and the population estimate are statistically significant.

With the three symptom categories combined intersymptom correlations were calculated as follows; 0.263 with quarrelling, 0.252 with

emotional dependance, 0.229 with sadness or depression and with reluctance to share, 0.228 with instability of mood, 0.226 with excessive shyness, 0.210 with masturbation, 0.200 with destructiveness, 0.194 with diurnal enuresis, 0.189 with irritability, 0.179 with excessive reserve, 0.174 with food fads, and 0.173 with nocturnal restlessness.

Illustrative Cases

Nora has always been timid and lacking in self confidence but instead of improving she seems to be getting worse as she grows older. Her play is restricted to set games played in the immediate vicinity of her home. She usually plays alone for despite her physical timidity she is extremely bossy and invariably quarrels with her companions. Since before starting school she has been unable to travel by bus because when travelling she develops a cold sweat with a choking sensation and for this reason has not been able to visit shopping centres for several years. She has numerous transient fears and is always afraid of dogs, cats, flies, moths, the dark, and thunder and lightning, sometimes exhibiting real terror.

A restless, fidgetty girl she is 'never still' by day or night, she has numerous food fads and finds something wrong with every meal. Her nails are always well chewed down. Often she chews her hair or the collar of her dress and when tired she sometimes sits pulling out

one hair after another causing a patchy alopecia. At school she is restless and inattentive but manages to maintain a reasonable position in class. It is sometimes difficult to get her to school and on one or two occasions she has run home during school time because she was afraid that a teacher was going to punish her. It is always difficult to know when she is telling the truth and though much of her romancing is transparent, it sometimes leads to difficulty. On one occasion when asked a question she could not answer she told her teacher that she could not see the blackboard and this caused a considerable stir. She was urgently referred to an eye specialist to whom she admitted, after extensive investigations that she had complained of near blindness rather than admit that she had not been taking notice of the lessin.

Nora is markedly overdependant on her mother who must always be near at hand, ready to pet her and reassure her. When playing in the garden she is constantly running indoors to make sure that her mother is still there. She is unduly sensitive to criticism, cries easily, either weeps or flies into a rage when denied anything, and is unable to entertain herself, showing little interest in her toys.

When she was seven years old she attended a psychiatric clinic for several months because of 'nervousness and weepiness' but after some initial improvement her behaviour relapsed. Her only serious

physical illness was an attack of gastroenteritis at the age of ten weeks which necessitated a three week stay in hospital. When two and a half years old she was admitted to a Residential Nursery for three months whilst her mother was in a mental hospital. At five and a half her extreme restlessness gave rise to a suspicion of rheumatic chorea and she was admitted to hospital for investigation. Acute rheumatism was excluded but she spent two weeks in hospital and a further three weeks at a convalescent home.

Nora is the third child in a family of four. Her younger sister by two years was born with a spina bifida and died at the age of five years. Her mother has undoubtedly had many difficulties to cope with and has managed to maintain an adequate, though none too clean, home. On the other hand she is a grossly neurotic woman preoccupied with her own ill health and lacking in sympathy for others. She has little real affection for the children who are constantly being told by her of their mother's martyrdom and their own inadequacy.

Nora's father is an ill tempered and self centred man who has very real difficulties of his own. His relationship with his wife is unsatisfactory and, in the past he has formed several associations with other women, deserting the family on several occasions before Nora was born. Just before Nora was born he had to give up his job as a miner when he developed a slowly progressive paraplegia due to

disseminated sclerosis. This condition did not curtail his amorous adventures and for the first two years of Nora's life he continued his association with various women and kept late, irregular hours. With the progression of his neurological condition he has become totally paraplegic and is forced to live a domesticated existence and this has done little to improve his temper. He has an invalid car and now manages to work intermittently as a clerk in a Ministry office. He has always been mean with money.

Illustrative Case

Katherine is quite fearless and many of her actions are so foolhardy as to have given rise to the suspicion that she might be grossly mentally defective. As a toddler she would climb over a garden fence, often falling, and wander onto the main road. A little later her favourite pastime was chasing motor buses as they ascended a steep gradient near her home. Her main playground is in derelict houses and many mothers will not allow their children to play with her because of her activities. She is regarded as a rip and a tom boy who will try anything. Although she is of poor intelligence her actions are inconsistent with her general ability, she appears to be unable to learn from experience.

She is extremely moody, temper tantrums having started when she was a toddler and she still has daily tantrums, often without evident

cause, in which she screams, tears her clothes, and throws things. On one occasion neighbours called in the police because of the child's screams thinking that she was being ill treated. Although she is frequently thrashed, in this instance it was she who was violent and the policeman who called sustained a bruised shin for his trouble.

When she started school she settled well for a few weeks but then began to kick her teachers when chastised and thereafter would often wander off to the park instead of going to school. She now attends fairly regularly but still truants occasionally and often fails to return home from school until after 10 p.m.

Katherine is totally lacking in reserve and since the age of four years has had the habit of soliciting passers by for money to buy sweets, often having a temper tantrum in the street if they refuse. Her general behaviour, irritability, and temper make her an unpopular companion and she has no real friends.

Apart from a few episodes of sleepwalking at the age of five years she has not been restless at night but during the day she is extremely overactive. According to her mother she 'sits as if she were on hot bricks and never stays on a chair for two minutes'. Her appetite is enormous but she is very faddy and difficult to please. Although she appears to be excessively independant and incapable of affection she is markedly attention seeking and must always

be in the centre of things. At present she attends an ordinary secondary modern school but her I.Q. is in the 70-80 range and her behaviour in school is likely to lead to her transfer to a residential school for educationally sub-normal children in the near future.

At the age of six months Katherine spent seventeen days in hospital because of a cervical abscess; at five and a half years she developed pneumonia and spent a further ten days in hospital followed by two weeks in a convalescent home. Apart from these illnesses she has been a very healthy child though since starting school she has had regular episodes of abdominal pain and severe recurrent headaches.

Her father is an inadequate irresponsible individual who was discharged from the army as of psychopathic personality. He was never able to keep a job for more than a few weeks and frequently deserted his family, finally leaving the household when Katherine was three years old. During his three years 'at home' he left the household many times, including three periods, each of three months, spent in goal for theft.

Katherine's mother is a dirty plausible woman completely lacking in affection for the children and incapable of maintaining reasonable physical standards in the home, despite an adequate income. She has one boy a year older than Katherine but by a different father, and three younger children by her present paramour.

Katherine's 'stepfather' moved into the household as a lodger whilst her father was in gaol, her mother became pregnant to him and has continued the association since. He is anexpatriate Pole who just before entering this household sustained a minor injury whilst working as a collier, and exploited the compensation aspects to the full. With his compensation he paid the deposit on a large house in a tenemented area and has since lived on the exhorbitant rents he obtains by letting 'rooms'. He is said to be strict but kind with the children but is unable to make any contact with Katherine and, like her mother, thinks she should be "put away in a home".

26. FEARS

(1) Extreme, acutely incapacitating fears — may be of dogs, high places, dark, etc.

(2) Upsetting but non-paralysing fears.

(3) Real discomfort or tension from fears but no real panic.

(4) A number of fears, with slight, usually diffuse apprehensiveness.

5 No real fears but legitimate caution and perhaps timidity of specific objects or situations

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	1	2	0	0	0	0
(2)	6	4	3	2	1	2
(3)	8	8	2	4	2	0
(4)	11	10	4	10	3	2
5	50	26	50	30	9	3
6	6	3	1	0	0	0

Mal. as Controls
$X^2 = 5.9$ $P < 0.02$

	BOYS %	GIRLS %	TOTAL %
Maladjusted Group	34.2	48.0	39.7
Control group	15.3	34.8	23.8
Population estimate	20.3	37.7	27.6

Diff. = 2.18 times standard error

FEARS

In Ackerson's (1931) study 3% of boys and 4% of girls were recorded as having childish fears but 14% of boys and 12% of girls were described as apprehensive. It is probable that many of the children recorded as having fears in this study would have been described by Ackerson as apprehensive. Unspecified fears were a feature in 33 of the 200 children with behaviour problems reported from paediatric practice by Craig (1956) and Lewis (1954) recorded morbid fears in 12% of her study group. Fifty (39.7%) children in the maladjusted group and 25 (23.8%) of the controls were recorded in this study as showing specific fears. ($X^2 = 5.9$ $P < 0.02$)

In all groups the symptom was commoner in girls than in boys and the differences in the population estimate is significant. The population estimate is 20.3% of boys and 37.7% of girls.

Intersymptom correlations were 0.329 with attention demanding, 0.318 with excessive shyness, 0.232 with undue sensitivity, 0.215 with emothional dependance and 0.179 with soiling.

Illustrative Case

At the age of eighteen months Freda and her six month old brother each had a moderately severe attack of whooping cough and they were kept indoors for several months. Towards the end of this illness Freda

became rather weepy and miserable and, for the first time, was afraid of strangers, cowering away if anyone approached and screaming to be taken home if anyone actually spoke to her. She was terrified of buses, refusing to board one and becoming agitated as they passed in the street. She also developed a fear of going into shops and would refuse to accompany her mother beyond the entrance.

When aged two years three months she awoke one morning with a mild cold and refused to walk, complaining that she could not stand. Her mother, fearing polio, became agitated and took the child to her doctor. In the surgery she was placed on a couch and as the doctor approached her she jumped down and ran from the building screaming. Since this incident she has been terrified of doctors but her other fears diminished in intensity and by the age of four years she could go into shops and travel by bus.

At the age of five and a half years she had a severe attack of bronchitis and the possibility of tuberculosis was raised by the family doctor causing considerable distress to the parents. A course of penicillin injections was prescribed for this illness and during the third injection with the child struggling a hypodermic needle broke in her buttock. Since then Freda's fear of doctors has been intensified and she is terrified of needles, the sight of a hypodermic syringe producing a reaction of marked panic with screaming.

A few weeks after the incident of the broken needle, Freda developed psoriasis which gradually cleared up over the course of two and a half years. Her skin remained clear until she was aged nine years when she had an injection, after a violent struggle, and within a month the psoriasis reappeared. This convinced her mother thatthe condition was due to the injections and when she discussed this matter with a local vicar it was arranged that 'the laying on of hands' should be tried in church. When Freda was taken to church for this ceremony she became apprehensive and as the vicar approached she ran out screaming. As a result of this incident, arrangements were made for her to see a psychiatrist and she is still under psychiatric superivision.

When her first fears developed at the age of eighteen months she was also restless at night, generally miserable, bad tempered and jealous of her younger brother. Her good vocabulary at this time became extended by the addition of numerous swear words which she used frequently to the great distress of her rather proper relatives. At three years and nine months she began to wet the bed and bite her nails and both these habits have persisted. Her mother is also concerned by her rapid mood swings, saying she is 'up in the air one minute and right down the next'.

Her mother is a placid, capable, rather impulsive woman who dominates her family including her husband whose lack of ambition

she resents. Whilst she appears to have good relations with the two children she tends to overprotect them and has rather high expectations of them. A regular Anglican church worker herself, she insists on the children attending church regularly but her husband, nominally a Roman Catholic, takes no interest in their religious education.

Freda's father is a quiet unassuming and unambitious man who works regularly as a lorry driver, 'it took a war to make him change his job'. Although fond of the children he does not have a close relationship with either of them and leaves their management entirely to his wife.

27. TEMPER

(1) Severe temper explosions, physical violence or verbal display. Accompanied by marked emotional reaction and loss of control.

(2) Screaming with accompaniments such as stamping feet and with some loss of control.

(3) Mild activity with less intense screaming or as severe as (2) but over quickly.

4 Fretting or moderate non-overt rage (includ unelaborated "bad tempered" etc.)

5 Anger reactions practically non-existent.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL.		MAL. /CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	5	6	1	1	2	0
(2)	8	0	1	2	4	1
(3)	26	9	16	8	3	0
4	27	22	33	25	4	3
5	10	4	8	10	2	3
6	23	14	0	0	2	1

Mal. as Controls
$x^2 = 11.1$
$P < 0.001$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	51.3	48.0	50.0
Control group	30.5	24.0	27.6
Population estimate	36.5	22.6	30.7

TEMPER

Lewis (1954) reported temper outbursts in 14% of a group of deprived children. In a group of 200 children with behaviour problems refered to a paediatric clinic Craig (1956) found that 20% had temper tantrums of problem intensity.

Ackerson (1931) reported temper tantrums in 11% of his group and temper display, other than tantrums, in 12% of boys and 8% of girls. These figures approach the findings in the control group of the present study but no less than half of the maladjusted group were recorded as exhibiting excessive temper displays. In Craig's (1956) study 20% of children were reported as having frequent temper tantrums.

Sixty three of the maladjusted group and 29 of the controls came within the arbitrary abnormal range for temper ($X^2 = 11.1$ $P < 0.001$).

The symptoms were commoner in boys than in girls in both groups but not significantly so. The population estimate which is 36.5% for boys and 22.6% for girls again did not show a statistically significant difference.

Intersymptom correlations were 0.366 with disobedience, 0.363 with irritability, 0.321 with emotional dependance, 0.318 with motor

overactivity, 0.311 with instability of mood, 0.243 with lack of self reliance, 0.202 with wandering, 0.196 with nocturnal restlessness, 0.195 with lying, 0.184 with food fads, and 0.181 with stealing.

Illustrative Case

Until the age of three years Carol had frequent 'kinks' or breath-holding attacks which her mother felt were due to sheer rage. Since then she has been quick tempered and sulky having frequent temper tantrums in which she is impossible to deal with. Although the more florid tantrums are becoming less frequent severe tantrums, in which she kicks, screams and lies on the floor drumming her heels still occur weekly whilst less severe displays occur several times a week.

She has a very variable appetite but is consistently faddy, refusing to eat any fish or vegetables and must fruits. Since starting school she has persistently picked her nose, often making the nostrils sore and has become something of a romancer. At home she often appears lifeless and unable to be bothered with anything but she apparently plays quite actively at school. She is very attached to her mother, craves to be nursed and petted and becomes very tense if mother is not at home. She likes to be the centre of attraction within the family but is shy and reserved with others and resents visitors in

the home. Her parents have to guard their words as she is extremely sensitive and easily upset and liable to either burst into tears or have a temper tantrum is offended. Mother considers her to be generally overactive emotionally and her mood is very labile.

This behaviour has developed against a background of physical illness, family disturbance, and prolonged separation. Carol developed pneumonia at the age of ten months and this was followed by recurrent attacks of wheezing. By the age of eighteen months she had a frank bronchiectasis which was so troublesome that at the age of 8 years, by which time she had been in hospital seven times, she had a left lower lobectomy. She was extremely disturbed and unco-operative during the post operative period and this probably contributed to the failure of the lung to re-expand as a result of which she was submitted to a total left pneumonectomy. Since that time she has continued to have frequent but less disabling attacks of wheezing and is now attending a school for physically handicapped children.

Carol's mother is an easy going, placid and rather slap-happy woman who often seems untroubled by major family upheavals. She regards her marriage as an unhappy lot but is genuinely fond of her children, Carol being the eldest of four.

The family lived, with the maternal grandparents until Carol

was over six years old and her father was regularly at loggerheads with his in-laws. He was employed as a tradesman electrician when Carol was born and worked fairly regularly though with frequent changes of job. Throughout the marriage he has been irresponsible in financial matters, 'a great spender', and an enthusiastic user of hire purchase facilities. His quarrells with his mother in law were said to be the main reason for his joining the Merchant Service when Carol was three years ten months. He returned home only once during the next fourteen months and his wife then received an invitation from his American 'fiance' to attend his 'wedding' in New York. Correspondance between the ladies resulted in his 'fiance' breaking the engagement and his wife obtaining a separation order. He threatened to kill his wife for disturbing his plans but when Carol was aged six and a half years his wife was persuaded to "have him back for the sake of the children". Since that time he has lived at home working regularly but still changing his job frequently. Though the marriage is not a happy one the family does appear to have achieved a certain stability.

28. IRRITABILITY

(1) Chronically irritable or fretful, on edge; easily upset by sensory environment.

(2) More irritable, fretful and reactive than average.

3 Normally reactive, occasional flare-up.

4 Rarely annoyed or disturbed.

5 Extremely phlegmatic.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	3	1	0	1	0
(2)	28	13	9	8	2	2
3	40	29	42	33	9	4
4	6	5	5	5	2	1
5	0	0	2	0	1	0
6	0	0	0	0	0	0

$X^2 = 9.8$
$P < 0.01$

	GIRLS%	BOYS%	TOTAL%
Maladjusted group	39.5	32.0	36.5
Control group	17.0	17.4	17.1
Population estimate	17.6	18.9	18.1

IRRITABILITY

In Ackerson's (1931) study 19% of boys and 14% of girls were described as having an irritable temperament. Again his figures are nearer the findings in the control group than those of the maladjusted group of this present study. Forty-six (36.5%) of the maladjusted group and eighteen (17.1%) of the control group were in the problem categories ($X^2 = 9.8$ $P < 0.01$).

In the maladjusted group 39.5% of boys and 32% of girls showed this symptom whilst in the control group the figures were 17% of boys and 17.4% of girls. The population estimate is 17.6% for boys and 18.9% for girls.

Intersymptom correlations were 0.424 with motor overactivity, 0.413 with disobedience, 0.400 with instability of mood, 0.363 with temper, 0.298 with attention demanding, 0.254 with jealousy, 0.251 with quarrellsomeness, 0.234 with undue sensitivity, 0.189 with physical timidity, and 0.176 with emotional dependance and nocturnal restlessness.

Illustrative case

Isobel, the second child in a family of eight, has always been a fretful, irritable child. Since infancy she has had frequent tantrums, which still occur daily, in which she lies on the floor kicking

and screaming. These upsets occur for trivial reasons and her mother says 'nobody dare say a thing to her.' She is surly and illtempered with other children and suspicious and resentful with all who come in contact with her.

Her personal possessions are usually well cared for and she keeps her toys for many years but strongly resents anyone else playing with them; 'she goes up in a blue light if anyone touches them.' Although her appetite is very good she has numerous food fads, which include all vegetables, and she goes into a rage if her food is not just as she likes it. She has no real friends and is aggressive towards other children, unable to stay in a group for more than a few minutes without starting a quarrel.

At home she is fiercely indépendant, resenting any attempt to help her or otherwise interfere in her activities and is generally overactive. With strangers she is sullenly timid and at school blank and withdrawn; she will stand mute and immobile if allowed to do so and at times her attitude together with her poor peripheral circulation is reminiscent of a catotonic state. She has never shown any interest or ability in school work and with her elder brother now attends a school for educationally sub-normal children.

Her speech developed slowly; she remained almost unintelligible until she was five years old and continued to have speech therapy

until the age of nine years. She has a well marked strabismus and an associated visual defect, for which she receives out patient treatment. As already mentioned Isobel has a poor peripheral circulation and this is associated with chillblains on her feet and hands. At the age of two years she had a moderately severe hepetic stomatitis and the consequent dehydration led to a stay in hospital of two weeks. Until recently she has suffered from mild but frequent upper respiratory infections and at five she had her tonsils and adenoids removed spending another week in hospital. She was not visited by her parents during either of her periods in hospital. When Isobel was eight years old her mother attempted suicide by taking an overdose of barbiturates and was in hospital for three weeks.

The mother is a worn dispirited woman who is quite unable to cope with her house and family. The house is dirty and untidy, the children are poorly fed, often inadequately clad and usually dirty. She appears to manage her children reasonably well until they can toddle and then leaves them 'to bring themselves up'. All of her children are defiant and undisciplined but even in this atmosphere Isobel is regarded as 'difficult'.

Isobel's father is a rought uncouth labourer of limited intelligence who works only when he can see no alternative. He makes a negligihle contribution to family life, except as a bogeyman for mother's constant cry is 'wait till your father comes in.'

There is little affection in this family, the parents are constantly quarrelling with each other and the children andthe family appears to be held together by sloth and indifference.

29. DISOBEDIENCE.

(1) Persistent disobedience, frank defiance, negativism. "No, I won't", a standard response.

(2) Disobedient but responds to pressure. Usually evasive rather than defiant.

3 Fairly pliable.

4 Rather more obedient than average.

5 Excessive docility. Unusually biddable.

6 Previous symptoms.

Category	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	8	0	1	1	4	1
(2)	20	16	10	5	6	0
3	44	28	46	40	4	4
4	3	5	2	0	1	2
5	1	1	0	0	0	0
6	6	3	0	0	2	0

$\chi^2 = 9.4$
$P < 0.01$

	GIRLS%	BOYS%	TOTAL%
Maladjusted group	36.8	32.0	34.9
Control group	18.6	13.0	16.2
Population estimate	28.4	13.2	22.1

Diff. = 2.1 times standard error.

DISOBEDIENCE

Nineteen per cent of boys and 15% of girls were classed as 'disobedient' in Ackerson's (1931) study. Again the figures for the present study are considerably higher, the symptom being recorded in forty four (34.9%) of the maladjusted group and seventeen (16.2%) of the controls. ($X^2 = 9.4$ $P < 0.01$).

There was no great difference in sex incidence in the maladjusted group, 36.8% of boys and 32% of girls, or in the control group, 18.6% of boys and 13% of girls. The population estimate however is 28.4% of boys and 13.2% of girls, a statistically significant difference.

Intersymptom correlations were 0.413 with irritability, 0.397 with attention demanding, 0.366 with temper, 0.317 with jealousy, 0.292 with motor overactivity, 0.244 with instability of mood, 0.240 with emotional dependance, 0.238 with lack of self reliance, 0.214 with destructiveness, 0.196 with wandering, 0.185 with thumbsucking, and 0.178 with lying.

Illustrative Case

Raymond after periods of intense negativism during his second and third years became increasingly disobedient and defiant and is now regarded at home as unmanageable. His prompt response to any

situation is 'No I won't' and his attitude is unaffected by bribery or punishment. At school he is sullen and resentful of authority, truanting whenever the opportunity presents.

As a toddler he had 'kinks' and tantrums and still has 'a wicked temper'. According to his grandmother 'you wouldn't dare go near him in a temper, he's violent'. At the age of five years he was caught stealing money from a neighbour's home and goods from a local store but no action was taken. Since that time he has indulged freely in petty and usually pointless larceny but despite several visits from the local police has never been prosecuted.

Since the age of two years he has been an inveterate wanderer, and is often missing from home from early morning until late in the evening. He frequently gets up in the night when the rest of the family is asleep and 'just goes for a walk' staying out most of the night. It is difficult to obtain any information about these excursions because Raymond is a persistent liar.

He has always been nocturnally enuretic and by day is fidgetty and restless. Although destructive with clothes and toys he is reluctant to share any of his belongings, including the proceeds of his thefts. Adventurous to the point of foolhardiness, he has climbed all the high buildings in the district and seems quite oblivious to the danger involved. He is inclined to be moody, has no real friends

and seems incapable of affection for others. He is extremely independant and resents any help, interference or sympathy from anyone. At school he is regarded as backward but not educationally sub-normal.

Raymond is the eldest of a family of four; his first sister was born when he was one year and two months old, a brother arrived a year later and another sister just before he was five years old. His mother died when he was aged five years and three months, having been in poor health for several years due to tuberculous kidneys. She was a thin harrassed woman who suffered from intermittent depression. Overburdened by her family, an inadequate income and an irresponsible husband she worked as a domestic cleaner and struggled to look after her family. Even during her final illness she would get out of bed to cook her husband's meals. Although her standards of care and supervision were inadequate she gave her best and had some genuine affection for the children. As a result of the home circumstances Raymond was left very much to his own devices as a toddler, spending a great deal of time outside his home.

At the age of two years he was in hospital for three days because of an alimentary infection and from the age of two until starting school he attended a day nursery. He had a mild dyslalia which was not treated and shortly after starting school developed a transient stutter which recurs when he is excited. His general health has been

good but, whilst he has had no major illnesses, the standard of observation in the home is poor and he may well have had more illness than has been rep orted.

Raymond's father is a heavy drinker who works irregularly as a casual labourer. He treated his wife as a pack horse and was often violent towards her and the children for whom he has no real affection. Since the mother's death the family have lived with the maternal grandmother but father is contemplating remarriage and if this occurs, he proposes to leave the children with their grandmother.

The grandmother is a dirty, harsh, grasping woman devoid of affection for the children but prepared to 'look after them' so long as she gets an allowance for doing so. She is, however, unwilling to continue to look after Raymond if his father leaves and thinks that 'he'll have to go into a home'. Her house is dirty and foul smelling and the children poorly clad and inadequately fed. In view of these factors and the lack of affection in the home removalto the care of the Local Authority, particularly if long term foster care could be arranged, would seem to be the best course for dealing with this boy.

30. JEALOUSY

(1) Extreme jealousy shown overtly or by marked tension.

(2) Jealousy a constant source of tension.

(3) Mild jealousy or sibling rivalry with occasional tension.

4 No serious jealousy.

5 Never jealous.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./ CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	0	0	1	0
(2)	13	9	2	1	2	1
(3)	10	14	7	9	4	3
4	27	16	12	18	5	3
5	24	11	38	18	3	0
6	2	4	0	0	0	1

Mal. as Controls
$X^2 = 10.2$
$P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	32.9	46.0	38.1
Control Group	15.3	21.7	18.1
Population estimate	21.6	26.4	23.6

JEALOUSY

Levy (1937) found jealousy a prominent symptom in 30% of 844 children referred to a child guidance clinic but Ackerson (1931) reports the symptom in only 0.5% of boys and 1% of girls in his group. Most authors comment on the excess of girls showing the symptom and Foster (1927) found that of those children in whom jealousy was problem, two in three were girls.

In the present study the symptom was found in 48 (38.1%) of the maladjusted group and 19 (18.1%) of the controls ($X^2 = 10.2$ $P<0.01$) Although there was an excess of girls over boys showing the symptom in both the maladjusted and the control groups the differences, within each group, were not significant. The population estimate is 21.6% of boys and 26.3% of girls.

Intersymptom correlations were 0.388 with attention demanding, 0.317 with disobedience, 0.254 with irritability, 0.228 with sadness or depression, 0.197 with undue sensitivity, 0.188 with reluctance to share and a negative correlation of - 0.175 with inadequate appetite.

Illustrative Case

John's only sibling, a brother four years older than himself, has done very well at both Secondary Modern and Grammar School and his achievements have been a source of considerable pride to his

parents. The elder boy has always been held out as an example to John who bitterly resents this and feels that his brother gets preferential treatment. Although four years younger he feels that he should have the same privileges for instance regarding pocket money and bedtime, as his brother and is sullen and resentful when these are denied him. He goes out of his way to torment and pick quarrels with the older boy, deliberately damages his brothers belongings, and whenever possible will get him into trouble, by telling lies if necessary.

Since infancy he has been regarded as 'more trouble' than his brother in every respect though in fact he has had little illness of consequence. He had to be circumcised at home on his twelfth day of life because of 'excessive crying' and when a few weeks old, he was admittedto hospital, with his mother, for surgical treatment of a pyloric stenosis. He developed a few food fads at the age of two years and became rather excessive in his demands for attention, particularly at night when he cried to be taken into his parents bed. During his third year he began to wander away from home but this habit only persisted for a few months.

When he was nearly four years old he began another 'awkward phase' becoming disobedient and 'chewing' or irritable and for a short period develooped a facial tic and eye blinking. A few months later the eye blinking reappeared and a number of doctors were

consulted until eventually an opthalmologist prescribed spectacles for 'eye strain'. Since then the eye blinking with or without a facial tic has been constantly present, initially becoming worse when the boy was anxious but now, although still phasic, apparently unaffected by stress.

From the beginning John has been extremely apprehensive about school and for several months after starting, had to be accompanied to and from school by his mother. Even until recently his mother had to accompany him for a few days whenever he changed his class or teacher. He still hates school and although he has never actually truanted it is sometimes difficult to get him there. During his holidays any mention of his impending return to school produces an atmosphere of gloomy anxiety. Despite this attitude he has gained a Grammar School place and is making good progress there.

At the age of eight years he developed a stutter which comes on only if he is exicted or upset. On two or three occasions in the past two years he has been caught stealing small sums of money from his mother's purse and has been very ashamed and penitent on each occasion. A few months ago he was arrested by the police when stealing a magazine from a bookstall, and at first he gave the police a false name and address but after enquiries he was identified and returned home. He appeared before a Juvenile Court and was placed on probation for two years for this offence. His mother was

acutely distressed by this incident feeling that it would bring degradation to the family and ruin to the boy. John is an independant lad, and has never confided in either of his parents who regard him as 'rather sly'. He is a ready liar, though usually only to avoid trouble, is rather shy with adults and keeps his finger nails well chewed. With other children he has to be 'the boss' and is often rather foolhardy in his exploits, perhaps to justify his assumption of leadership. Although he is inclined to be destructive with his toys, taking them to pieces 'out of curiosity' he resents sharing them with others. At home he is rather easily upset and disobedient and defiant with his parents.

His mother is a pleasant, efficient woman with high personal standards. She keeps her home clean and well scrubbed and tries to do the same with the boys. She is fond of her two sons and does her best to give them affection and understanding but is perhaps too conscious of doing her best for them. Her husband is a grocery store manager, abstemious, churchgoing and generally of excellent character but a somewhat shadowy figure in the household, taking little part in the boys' upbringing.

When John was six years old the family gave up their own home in order to live with a lonely olderly uncle, a decision which they have regretted ever since. The old man resents even normal noise from

the children who always have to be kept out of his way. At the time of John's appearance before the Juvenile Court mother's main anxiety was to keep this knowledge from uncle as she feared that he might evict the family.

31. ATTENTION DEMANDING

(1) Constant demanding of attention causing real disturbance in the household.

(2) Less than (1) but enough to be evident and annoying.

3 Seeks and enjoys attention but functions easily without it.

4 Less interested in attention from others than average.

5 Unusually self-reliant.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL. /CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	4	0	2	1	0
(2)	14	12	5	4	4	1
3	38	27	37	33	5	5
4	18	6	17	7	5	1
5	3	1	0	0	0	0
6	3	4	0	0	1	0

$X^2 = 8.2$
$P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	22.4	32.0	26.2
Control Group	8.5	13.0	10.5
Population estimate	13.5	13.2	13.4

ATTENTION DEMANDING

Craig (1956) regarded 8.5% of his group as demanding excess attention, but most other reports do not treat such behaviour as an independant symptom.

In the present study thirty three (26.2%) of the maladjusted group and eleven (10.5%) of the controls were included in the symptom categories of this behaviour item ($X^2 = 8.2$ $P < 0.01$)

Although the symptom was commoner in girls (32%) than in boys (22.4%) in the maladjusted group and in the control group (girls 13%, boys 8.5%) these differences were not significant. The population estimate is 13.5% for boys and 13.2% for girls.

Intersymptom correlations were 0.400 with instability of mood, 0.397 with disobedience, 0.329 with fears, 0.298 with irritability, 0.254 with jealousy, 0.250 with emotional dependance, 0.234 with undue sensitivity, 0.189 with quarrelsomeness, and 0.180 with food fads.

Illustrative Case

Beatrice is regarded by her unstable family as a 'show off'. She must always be the centre of attraction and uses all manner of devices to achieve this. At home she monopolises any conversation and if visitors fail to make a fuss of her she becomes irritable

and fretful, usually finding some excuse to have a temper tantrum. She dominates her inadequate mother, talking to her as if mother were a child, yet she is very clinging and dependant becoming very upset if mother leaves the house without her. At school she is regarded as a nuisance by her teachers because of her constant demands for attention.

In this rather squalid household she is 'queer and far too careful' because she is forever washing herself and demands frequent changes of clothing, perhaps two sets of underwear in a day. She takes great care of her clothes and toys and is very possessive with them, refusing to share or lend any of her belongings. A bad tempered child, she has frequent temper tantrums, several times a day when she cannot get her own way, shouting, screaming, and throwing things about the house. Her mother 'can do nothing with her' as she flies into a tantrum when any attempt is made to correct her or give her orders. Beatrice is terrified of the dark and of storms and used to get frequent nightmares but these now occur only once a month. Her mood is variable and unreliable and though she appears to have plenty of friends she is very quarrelsome, and whilst refusing to share any of her own belongings is jealous of other children's property.

Beatrice has never been in hospital and her only serious illness

was an attack of pneumonia at the age of seven months. At the age of five months she spent five weeks in a residential nursery and had a further two weeks there at the age of one year three months. During her third year she attended a day nursery for ten months and at the age of nine years she spent two weeks in a Children's Home. Each of these stays in residential homes was due to her mother's absence on convalescence.

The family now consists of Beatrice, her two elder brothers and her mother living together in a filthy two roomed flat in a pre war barrack type block of flats. Her eldest brother has recently joined the army as a regular soldier whilst the other remains at home, usually unemployed, and on probation for theft. Mother is a woman of dull normal intelligence and inadequate personality who has long since given up the unequal struggle to maintain any reasonable standards. She hassuffered from 'nerves and depression' since first known to the investigation and frequently takes to her bed for days or weeks with ill defined illnesses. For two periods of about a year she worked as a kitchen hand but otherwise has spent most of her time crouched in an armchair near her own kitchen fire. At times she has expressed suicidal ideas but has never made a suicidal attempt. She is, however, sufficiently active to manipulate various social agencies to obtain help in kind

and several 'convalescent holidays' for herself.

Beatrice's father is a lorry driver who works regularly and was described as a 'smart clean tidy man interested in his family'. His wife claims to have lived in terror for several months after Beatrice was born as she had found her first daughter dead in her cot at the age of three months and her husband threatened to murder her if anything happened to Beatrice. He attempted to keep his wife up to scratch, insisting on attempts at decorating and spring cleaning but it is evident that he made little effort to help his wife in these things and was usually out at night returning in the early hours of the morning. His wife asserts that he is a heavy drinker and has had frequent associations with other women. When Beatrice was two years two months old he deserted the family but kept in touch with them and offered to return if his wife 'cleaned up the house and got rid of the fleas'. He did return home after seven months but when Beatrice was three years four months old he finally deserted the family and has not been seen since.

32. SENSITIVITY.

(1) Supersensitive, sees adverse criticism when not intended and shows marked reaction to it.

(2) Easily hurt, upset by any adverse comment or criticism.

3 Normal response to approval or disapproval.

4 Matter of fact, impersonal.

(5) Callous, indifferent, unconcerned. "No feelings".

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	6	1	2	1	1	1
(2)	42	25	26	17	11	4
3	24	20	28	26	1	2
4	4	2	2	1	0	0
(5)	0	1	1	0	1	0
6	0	0	0	0	0	0

Mal. as Control
$x^2 = 4.5$
$P < 0.05$

	BOYS	GIRLS	TOTAL%
Maladjusted Group	63.1	52.0	58.7
Control group	47.4	39.0	43.8
Population estimate	54.0	43.4	49.6

SENSITIVITY

Although undue sensitivity was reported by Ackerman in only 13% of boys and 10% of girls in his large maladjusted group the symptom was the commonest recorded in the present study. Seventy four (58.7%) children in the maladjusted group and forty six (43.8%) of the control group. ($X^2 = 4.5$ $P < 0.01$).

The symptom was commoner in boys than girls being recorded in 63.1% of boys and 52% of girls in the maladjusted group and 47.4% of boys and 39.0% of girls. Again in the population estimate boys (54%) are in excess of girls (43.4%) but none of the differences are significant.

Intersymptom correlations were 0.320 with sadness or depression, 0.279 with attention seeking, 0.252 with fears, 0.235 with instability of mood, 0.234 with irritability, 0.229 with quarrelsomeness, 0.196 with excess reserve, 0.191 with excessive shyness, and a negative correlation of - 0.268 with thumb sucking.

Only three children, one from each of the main study groups were recorded as showing callousness or lack of sensitivity and in none of these was this a major item of behaviour disturbance. In view of this no case history is given for this item.

Illustrative Case

Kenneth is the younger by six years of two brothers of markedly dissimilar personality. Whereas the older boy was a 'bit of a rip' and never troubled with nerves, Kenneth has always been a tense, sensitive boy. He is very easily hurt and all members of the household have to choose their words carefully as he is 'liable to pick them up wrong and burst into tears'. 'If you get the least bit cross with him he's so terribly hurt you wish you hadn't shown it'.

According to his mother he has 'no go in him' and is too good to be true. He is never disobedient though his mother would feel happier if occasionally he were. He is extremely shy, avoids visiting or meeting people whenever possible and is a solitary boy with few friends. Although he plays little with his toys he keeps them tidily stored and bitterly resents any attempt to make him share his possessions.

He has always worried about school and during his first two years at infant school there was a regular morning scene in which he refused to go and almost had to be carried there. In recent years he has attended without difficulty but still worries a good deal about his school work and has periods of acute anxiety associated with changes of class or impending examinations. In general, he is said to be independant in the home but he relies a good deal on his mother,

often asking her to wash him or assist him in dressing. His mother feels that he is lacking in confidence and sets too high a standard for himself, thinking that he ought to do well at everything. He rarely shows any temper display and if he does he is upset and profusely apologetic afterwards. When asked about punishment his mother remarked that he had never been punished as 'he has never done anything wrong'.

Before starting school he had a marked dyslalia but his speech improved rapidly with therapy. Since he began school he has had recurrent attacks of abdominal pain which caused considerable anxiety during the first few years. His parents are now aware that the attacks come on when he is tense or worried, particularly about school activities, and have accepted them as part of the boy's make up. For the past two or three years he has also had frequent severe headaches but again no physical cause has been found. He has had no serious illness and has never been separated from either parent.

Kenneth's tense anxious mother has been under the care of her doctor for 'nerves' for several years, but is an excellent housekeeper. She had been satisfied with one child and resented her second pregnancy especially as the family were living with her mother who, throughout the pregnancy, castigated her for her carelessness. During Kenneth's early years his mother surrounded him with restrictions as

she feared 'something would happen to him'. He was never allowed unaccompanied beyond the garden gate until just before he started school and his mother took endless precautions to avoid accidents or infections. Her main preoccupation now is 'where have we gone wrong in bringing him up, we've always done our best for him.'

His father, a foreman steel erector, is a steady worker and an active member of the local community centre. He has never had a lot of time for the boys as he works long hours and has an active social life, but is said to be a good husband and father.

33. SADNESS OR DEPRESSION

(1) Very sad with periods of real depression either as part of stable personality or in prolonged depressive swings. Unresponsive to gaiety in others.

(2) Unhappy, serious minded but less profound than (1) with some environmental response.

3 Happy for the most part.

4 More cheerful than average.

5 Constantly cheerful and consistently over-optimistic.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	1	1	0	0	0
(2)	12	11	5	2	1	2
3	33	23	30	25	7	2
4	28	15	23	19	7	3
5	0	0	0	0	0	0
6	2	2	0	0	0	0

Mal. as Cont.
$X^2 = 7.5$
$P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	19.7	24.0	21.4
Control group	10.2	4.4	7.6
Population estimate	9.5	7.5	8.7

SADNESS OR DEPRESSION

In Ackerson's (1931) study depression was reported in 6% of boys and 5% of girls and undefined 'crying spells' in 22% of boys and 24% of girls. Craig (1956) found depression a significant feature in 19 of a group of 200 children refered to a paediatric clinic because of problem behaviour. An unhappy disposition was recorded in 27 (21.4%) of the present maladjusted group and eight (7.6%) of the controls. ($X^2 = 7.5$ $P < 0.01$)

There were no significant differences in six distribution, the symptom being recorded in 19.7% of boys and 24.0% of girls in the control group. The populatinn estimate is 9.5% for boys and 7.5% for girls.

Intersymptom correlations were 0.410 with excess reserve, 0.329 with emotional dependance, 0.320 with undue sensitivity, 0.289 with instability of mood, 0.267 with excessive shyness, 0.229 with physical timidity, 0.228 with jealousy, 0.212 with nocturnal restlessness and 0.199 with reluctance to share.

Illustrative Case

Thomas has always been a sad looking unsociable boy who stands unhappily detached from other children apparently unable to join in their play. He is never happy, at best he is 'solemn and serious'

and at times he has dark moods when he is miserable, tearful, and refuses to talk to anyone. These periods of depression may last for several days and he usually comes out of them slowly. He has always wet his bed at night and until the age of ten years he wet his trousers regularly. Until the age of nine years he soiled his trousers daily and still does so occasionally. During the day he is restless and overactive 'like a cat on hot bricks', and at night he frequently talks in his sleep, often becoming very excited.

He chews his clothing, particularly woollens and coat lapels, and is always chewing his nails. For several years he has been known to take toys from smaller children and in recent years he has been stealing small sums of money from home. He is inclined to be destructive with his own toys but is reluctant to share his possessions with anyone. His play is inclined to be childish for his age, and as he has no friends he often sits in solitary play with toy cars and horses for several hours.

Always extremely shy with adults and children, he appears sullen and withdrawn. He is very timid, easily bullied, and has numerous fears being terrified of carpet sweepers, the dark, and thunder and lightning. At home he used to be sullenly negativistic but is now fairly obedient though he often has temper tantrums. Recently he kicked a hole in a new wardrobe during a tantrum and because of his temper none of his relatives will take him for a holiday. At

school he is often in trouble because of truancy and lying, seems to be a butt for his school fellows, and is regarded by his headmaster as educationally sub-normal though he has not been formally ascertained.

Thomas has never had any serious illnesses and his separation experiences will be described in the following paragraphs.

He has two siblings, a sister five years older and another three years younger. His mother was a chronic infalid, due to rheumatic heat disease, until her death when Thomas was ten years old. She had spent an average of one month per year in hospital since Thomas was born. Her disability, the children, and a wayward husband were too much for her to cope with and despite occasional efforts to improve, her standard of care in the home were grossly inadequate, the children were often untidy and underfed. She frequently kept the children off school to help her and as she never knew when visited by the Education Welfare Officer whether Thomas had been truanting or helping at home she provided ready excuses. Her weary unhappiness made it difficult to assess her relationship with the children.

Thomas' father is a curious individual of markedly schizoid personality and though it has been suggested that he suffers from chronic schizophrenia he is more probably a schizoid psychopath.

He rarely remains in a job for more than a few weeks and he was irresponsible at home, keeping his wife constantly short of money and making several vicious attacks upon her. During his wife's lifetime he formed numerous associations with young women, at one time maintaining two households, and becoming formally engaged on several occasions. When his wife died he left home, taking the children's allowance books with him and has not been seen since.

The children are now in the care of their maternal grandmother, a domineering, self centred woman who is 'doing her best' for the children from a sense of duty. She regards Thomas as 'her cross' and though she is pleased with her success in 'training' him she has no affection for the boy.

34. INSTABILITY OF MOOD.

(1) Extreme instability of mood, periods of real depression or elation, (or mood volatile and unpredictable).

(2) More variable than average, frequent but not persistent mood changes.

3 Normal responsiveness to situations.

4 Only considerable pressure will produce mood swing.

5 Unusually stable, stolid or unreactive.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL. CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	4	1	1	0	0	1
(2)	17	16	7	6	5	1
3	52	32	49	40	9	5
4	2	1	1	0	0	0
5	1	0	1	0	1	0
6	1	2	0	0	0	0

Mal. as Cont.
$X^2 = 8.4$
$P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	27.6	34.0	30.2
Control group	13.6	13.0	13.3
Population estimate	17.6	15.1	16.5

INSTABILITY OF MOOD

Changeable moods or emotional instability were found in 10% of maladjusted girls and boys in Ackerson's (1931) study. In the present work the symptom was found in 38 (30.2%) of the maladjusted group and 14 (13.3%) of the controls ($X^2 = 8.4$ $P < 0.01$)

The sex distribution within the groups showed little variation, the symptom being found in 27.6% of boys and 34% of girls in the maladjusted group and 13.6% of boys and 13% of girls in the control group. In the population estimate 17.6% of boys and 15.1% of girls were recorded as showing this symptom.

Intersymptom correlations were 0.400 with irritability, 0.311 with temper tantrums, 0.295 with motor averactivity, 0.289 with sadness or depression, 0.249 with lying, 0.244 with disobedience, 0.235 with undue sensitivity, 0.228 with physical timidity, 0.216 with quarrelsomeness, 0.197 with jealousy, 0.184 with food fads and 0.178 with nocturanl restlessness.

Illustrative Case

Arthur is a very moody boy who has rapid and violent mood swings. On the whole he tends to be active, cheerful and boistrous but can change within seconds and without evident cause to a mood of tearful depression. Rarely these miserable periods last a day or

two but usually he is 'up and down' several times a day and his moods are completely unpredictable. He has always been irritable, 'the least little thing seems to annoy him' and though he has never had tantrums he is at times bad tempered, becoming sullen and clashing about.

Since the age of four and a half years, when his mother died, he has become disobedient and defiant, is 'always telling lies, and has become a wanderer. He goes off into parks, visits friends, or makes trips to the seaside and is often missing for hours. On one occasion he was found by the police wandering through a town twenty miles away, having scrounged a lift on a lorry. In the past six months he has improved considerably in that he now usually asks permission before going away.

At the age of five years, he began to soil his trousers and this occurred daily until the age of nine years when the symptom became less frequent and gradually disappeared. For a number of years now he has stolen small sums of money from neighbours, at school, and from home. These episodes have been intermittent and apparently unmotivated and so far, although punished by his father, he has not been prosecuted.

He is a fidgetty child with anenormous appetite, and he has a habit of twisting his face and screwing up his mouth which with his restless overactivity, has an irritating effect upon people around him.

A very independant boy he resents any help or superivision in his activities and is totally lacking in shyness, thrusting his way into any group. Although he is bossy he has plenty of friends, is usually a ringleader, and is regarded as foolhardy and 'game for anything'.

Since infancy, he has suffered from recurrent upper respiratory infections and now has a chronic suppurative otitis media which has occasional exacerbations. At the age of two and a half years he spent two weeks in hospital because of an acuteotitis media and then stayed for a month convalescing at his grandmothers. When he was three years old, his father was recalled to the reserve and was away from home for four months. His mother died suddenly when he was four and a half years old and since then, his only separation from his father was a period of two weeks in hospital following a road accident when he was eight years old.

Arthur's mother was a fairly competent but harrassed young woman who was under psychiatric supervision because of major epilepsy and chronic anxiety. She was fond of Arthur and his sister, who is three years younger, but was rather preoccupied with her own real difficulties. Her husband did not know of the epilepsy until after they were married and he was unsympathetic about her disabilities. When Arthur was four and a half years old his mother developed status epilepticus but her husband did not call in a doctor until she had

been in status for two days. She was immediately transferred to hospital but died within a few hours of admission.

Arthur's father, a harsh, unfeeling man works as a postman driver. He married again a year after his wife's death and his second wife has found the children difficult to manage. Father, however, adopts the attitude that his children are well behaved and refuses to discuss their problems, though despite this view he has little real affection for them.

The step mother was a widow who brought her four children, all older than Arthur, into the household and has subsequently had two other children. Arthur is said to get on well with the other children in the family but only now is he developing any relationship with his step-mother. The latter is a plump, pleasant, rather simple girl who has found her step-children perplexing but is making a genuine attempt to gain their affection. Her relationship with her husband is not a satisfactory one and she is very much afraid of him. She now feels that he married her for convenience rather than pay a housekeeper. When their two children were born he wanted to offer them up for adoption but she could not part with them and this has resulted in further disharmony.

35. EXCESS RESERVE.

(1) Extremely reserved.

(2) More reserved than average.

3 Normally expressive.

4 More expressive than average.

(5) Markedly less inhibited than average.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL. / CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	1	2	1	0	0	0
(2)	22	10	8	4	2	3
3	52	36	49	41	11	4
4	0	2	1	1	2	0
(5)	1	0	0	0	0	0
6	0	0	0	0	0	0

Mal. as Control.
(1) & (2)
$X^2 = 7.51$
$P < 0.01$

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	30.3	24.0	27.8
Control group	15.3	8.7	12.4
Population estimate	14.9	13.2	14.2

EXCESS RESERVE

It is difficult to know which of Ackerson's (1931) categories would correspond to this symptom group, and although he recorded 'bashfullness' in 14% of boys and 16% of girls this probably corresponds more closely with shyness in the present study. He reports 'lack of inhibitions' in 3% of all the children in his study.

In the present work 35 (27.8%) of the maladjusted group and 13 (12.4%) of the controls were recorded as showing excessive reserve and only one child in the study, a member of the maladjusted group, was considered to exhibit excessive lack of reserve. His case history is to be found described under the symptom of extreme competitiveness which follows.

The symptom was commoner among boys than girls in all groups but not significantly so. In the maladjusted group 30.3% of boys and 24% of girls were included in the symptom categories and the corresponding figures in the control group were 15.3% of boys and 8.7% of girls. The population estimate was 14.9% of boys and 13.2% of girls.

Intersymptom correlations were 0.410 with sadness or depression, 0.358 with emotional dependance, 0.338 with excessive shyness, 0.196 with sensitivity, 0.189 with food fads and 0.179 with physical timidity.

Illustrative cases

Dorothy is the middle girl in a family of four, her older sister being two years older and her twin sisters four years younger than she. According to her mother she 'always shuts up like a clam' when she meets anyone and never shows any feelings. At a school visit the medical officer noted 'A very remoted child giving only monosyllabic replies to questions, she has an air of detachment quite strange in a nine year old girl'. Her mother thinks that she is a serious child at school or outside but very happy go lucky at home where 'nothing touches her very deeply'.

For years visitors have remarked on this 'forlorn looking child' or commented that she 'froze' when spoken to. Her mother believes that she lacks confidence but keeps all her worries to herself. 'I feel there must be some worry there but I don't know what it's about'. Her teachers consider her to be a solitary, unhappy child who is timid and easily confused.

Since the arrival of the twins she has been very jealous, admitting frankly that she does not like them. She is very dependant upon her mother, always clinging, following her about the house and becoming very upset if her mother is not immediately available. Despite the presence of younger twins she is so demanding of attention that she absorbs most of her mother's time.

At six years of age she began to steal 'silly little things' from home. She seemed to select useless objects which she either gave away or concealed about the house. This became a serious problem for a few months but now occurs only infrequently. Dorothy is restless and lacks concentration though despite her difficulties she manages to hold her own at school. She has always been inclined to romance and at about the age of eight years the extent of her fabrications became a serious worry to her mother. For almost a year she seemed unable to tell the truth and would fabricate fantastic stories about her activities but she has improved considerably in this respect and now, with occasional lapses, she is fairly truthful.

Although she seems to have plenty of friends she is shy with other children and unable to tolerate quarrelling; she will never defend herself and prefers to withdraw at any sign of friction. She is terrified of thunder and lightning and is still afraid of the dark.

Dorothy has twice been in hospital, first during her second year when she was under observation for one week because of suspected congenital heart disease (which was excluded,), and again for a week during her sixth year when her tonsils and adenoids were removed. During her fourth year her mother was twice in hospital

for a period of three weeks in connection with the twin pregnancy and her father was also in hospital for six weeks during that year. Apart from the infectious fevers Dorothy has had no serious illness.

Her mother is a rather anxious but affectionate mother who deals moderately well with the household. During the past eighteen months she has taken a full time job to supplement the family income. Although she manages the other girls very well mother feels she has never understood Dorothy and cannot 'get across to her'.

Dorothy's father has worked regularly as a fitter and turner despite a troublesome peptic ulcer. He is a pleasant stable individual fond of the children and with no interests outside the home.

36. COMPETITIVENESS.

(1) Extremely competitive, always striving to outdo others; upset if he does not succeed, and gloating when he does.

(2) Enjoys excelling when the opportunity presents, put out or in a paddy if he loses.

3 Stimulated by competitive situations.

4 No real competitive relations, easily discouraged if losing.

(5) Discouraged in any competitive situation, prefers to withdraw.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	0	0	0	0
(2)	18	12	12	9	6	1
3	48	31	45	32	7	3
4	6	7	2	5	2	2
(5)	2	0	0	0	0	0
6	2	0	0	0	0	0

X^2 0.8
Not significant

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	26.3	24.0	25.4
Control group	20.3	19.6	20.0
Population estimate	24.3	18.9	22.1

COMPETITIVENESS

Thirty two (25.4%) children in the maladjusted group and twenty one (20%) children in the control group were recorded as extremely competitive but the difference between the two groups is not statistically significant. Two of the children in the maladjusted group were intolerant of competitive situations but again this may be a chance finding.

There was little difference in incidence between the sexes and the population estimate was 24.3% of boys and 18.9% of girls.

Intersymptom correlations were not calculated.

Illustrative Case

Edward is reported here as a child who strives to outdo others but this is merely one aspect of a gross family disturbance. He is a very small, puny child who so longs to excel, he will willingly cheat or lie to 'win' an unimportant game at school. With adults and other children he enjoys card and board games but becomes 'ill' or distressed if he is in danger of losing.

He is totally uninhibited in his social relationships and has never passed through a phase of shyness. Edward will engage total strangers in conversation in the streets, following them into public bars or wherever they are going, he will stroll into a police station

to talk to the desk sergeant and generally ventures 'where angels fear to tred'. At school he is attention demanding and forever monopolising the teachers time, he walks into the headmaster's office on transparent pretexts, and eagerly advances on any visiting school inspector or other stranger.

During one of his recent hospital admissions he was found sitting on his bed gazing soulfully at two pennies in his outstretched hand. When anyone passed by, porter, visitor or member of staff he said plaintively "I've never had any pennies of my own before, nurse says when I save three pennies I can have some chocolate". To the uninitiated the appeal was irresistable and another coin was soon forthcoming. At the first opportunity the newly acquired coin was carefully placed in a bulging money bag beneath Edward's pillow and his soulful two penny stance resumed for the next visitor.

He has been wet by day and night since infancy and in the past three or four years has regularly soiled his trousers. A restless, overactive boy he is unable to sit still at home or at school and his restlessness continues in sleep with tossing and turning and occasional sleepwalking. His appetite is poor and as his mother insists on him clearing his plate he hides food rather than eat it. For the past three years he has been an inveterate wanderer and has several times travelled by train to London or intermediate points. He is usually discovered on the train or on the doorstep of some

unfortunate suffering from 'loss of memory'. After removal to the nearest hospital he is usually able to identify himself and is soon reunited with his tearful, loving mother who, after arranging an interview with a newspaper reporter, will explain that it is all due to fits.

Like his mother Edward is an incorrigable liar and an active jackdaw thief stealing anything within reach. The proceeds of his thefts are usually thrown away or distributed among any children he happens to meet. According to his mother, and the national press, he is devoted to her. He refers to her by her surname, usually prefaced by Mrs., and his devotion to her cannot be detected by a normal observer. At home he has a violent temper and in his tantrums is destructive, throws things, turns on all the water taps and blows out gas jets without turning them off. Outside the home he is rather timid and fearful and is avoided by other children who regard him as a 'sneak'.

He was recently seen by a psychiatrist because of truancy and wandering, and his intelligence quotient was estimated at 73 (W.I.S.C); largely because of the home conditions he has been admitted to a school for maladjusted E.S.N. children. In the school he is reported to be helpfull, intelligent and well behaved, and 'the other boys look up to him'. However he continues to wet and soil his clothing,

is a persistent liar, and wanders off whenever the opportunity presents.

He has been in hospital on fourteen occasions, (apart from short stay visits with 'loss of memory') nine of these admission being during his first year of life and most of them have been unnecessary from a medical view point. His only serious illnesses have been gastro-enteritis in infancy and a moderately severe pertussis; he also sustained extensive second degree scalds on two occasions during his first two years of life. His hospital admissions were usually arrange on the basis of a history from his mother of an illness suggesting epileptic fits or meningitis but despite exhaustive investigation no objective evidence has ever been obtained to con-firm these 'fits'.

On several occasions during his first year of life, Edward was sent into hospital by ambulance unaccompanied. His mother is on record as having frequently used physical violence on the boy, having administered rat poison to him on one occasion, deprived the child of food to a point of near starvation, frequently locked him in a basement room without clothing or bedding, and on one occasion collected money for his wreath until the local health visitor called and found the boy very much alive.

His mother is an aggresive psychopath, an unscrupulous plausible woman who has systematically rejected the boy since birth. With at least one husband alive she has lived intermittently with Edward's

father for the past sixteen years. She is known to have produced thirteen live born infants, two stillbirths, and four miscarriages to various fathers. To her present spouse she has borne Edward, three elder brothers and a younger sister and this has been the family so far as the boy is concerned. A few years ago a joyous reunion with her missing children was arranged with due publicity by the national press. These children had been 'kept from her' since she sent them to their wartime evacuation foster homes leaving no home address.

Her home is clean and adequately furnished but bleak, she rules her children like a sergeant major and they are usually adequately cared for in a physical sense. Although she is generally lacking in affection Edward seems to have been singled out for particularly harsh treatment. She has been convicted several times for obtaining national assistance on false pretences and for fighting with neighbours but has each time escaped with a fine.1

37. MODESTY

(1) Extreme modesty, never lets anyone see him undressed or partly undressed. Upset during medical examination and if required to change clothing at school. Panic when seen even in underclothes.

(2) Embarrassed and uncomfortable when seen undressed.

3 Unconcerned in own circle.

4 Mild showing off, pleased with body.

(5) Enjoys parading about undressed, quite immodest.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	3	1	2	1	0	0
(2)	22	15	13	9	7	3
3	45	32	42	34	6	3
4	6	2	1	2	2	1
(5)	0	0	1	0	0	0
6	0	0	0	0	0	0

Mal. as Cont. (1) and (2)
$X^2 = 1.6$
Not significant

	BOYS%	GIRLS%	TOTAL%
Maladjusted group	32.9	32.0	32.5
Control group	25.4	21.7	23.8
Population estimate	29.7	24.5	27.6

MODESTY

Undue modesty was reported in 41 (32.5%) of the maladjusted group and twenty five (23.8%) of the control group, a difference which is not statistically significant. The 'symptom' was found in similar proportions in both sexes, 32.9% of boys and 32% of girls in the maladjusted group, 25.4% of boys and 21.7% of girls in the control group and a population estimate of 29.7% of boys and 24.5% of girls.

Immodesty was recorded in only one child, a member of the control group. No intersymptom correlations were calculated for this behaviour range.

Illustrative Case

No one has seen Peter undressed since he was six years old and even before this, he resented his mother bathing him and was embarrased if seen in his underclothing. Since the age of six years he has dressed and undressed himself in a locked bathroom and refused to allow either parent to assist in bathing him. If anyone tries the bathroom door whilst he is changing he becomes very agitated and if anyone outside the family sees him in his pyjamas he gets into a panic. For gym classes he goes to school wearing his gym vest and pants and at the end of the class dresses without changing.

Peter is the only boy of a family of five, two older girls and two younger by two and nearly five years. When he was nearly five years old, a few weeks after the birth of his youngest sister, the family moved from an old slum clearance property to a modern council house. They were all delighted with the bathroom but to Peter it became the centre of his life. During the first few weeks he was often missing and was always to be found in the bath. Gradually he came to spend less time in the bathroom but even now has at least one bath a day, in a family where the 'weekly bath' is regarded as an unwelcome chore.

When he was aged a year and nine months his third sister was born and he began to have nightmares, usually waking up in the night screaming that he was falling. At the same time he regressed in toilet training and had to be put back in nappies. The dreams and toilet difficulties persisted for a few months and then slowly cleared up.

From the age of two years he began to wander away from home and was several times brought home by the police. He would wander off by himself two or three times each week sometimes covering considerable distances. Since the age of about seven years his wandering has become more socially acceptable in that he continues his long solitary walks but usually seeks permission from his parents before setting off.

At the age of three years he began to soil himself again and this symptom continued regularly for almost a year before it ceased dramatically without treatment. He remained clean and apparently free from constipation until the age of eight years when daily soiling recurred. At first he managed to conceal this from his parents by washing his underclothes, but was soon discovered by his mother who, although extremely worried by this symptom did not seek medical advice. Peter's father was rather impatient with him and inclined to jeer at the boy but he was not punished. Daily soiling continued for nearly a year then becoming episodic and he now soils himself two or three times a month. Although his mother denies any enuresis his school-teacher reports that he often wets his trousers during the day.

Peter is a shy, solitary boy, reluctant to visit other people's homes and with few friends. Since starting school he has become very self conscious of a mild congenital ptosis. At home he is quiet and obedient but intensely restless. He prizes all his possessions and is extremely neat and tidy. He is inclined to seek attention but is never jealous of his sisters and really has little contact with them. Owing to overcrowding in the home he shares his room and bed with a younger sister, but, apart from his care in dressing and undressing, he does not seem to mind this.

He has never liked school though there has been no difficulty

in getting him there and he is regarded as of abovemaverage in ability. Before the 'Eleven plus' examination he became extremely agitated and apprehensive fearing that he might pass! His parents insisted on him taking the examination despite his protests and he was allocated a place in a Roman Catholic Technical School.

Peter has had no serious illness but spent two weeks in hospital at the age of ten and a half years because of an illdefined illness with generalised aching which was regarded as an acute myositis. He has never been separated from his mother but his father was away in the merchant service till Peter was four months old and when the boy was five years old worked away from home for six months.

Peter's mother is a placid, conscientious mother who has maintained reasonable standards on irregular and often inadequate wages. She is a competent housewife and a warm affectionate mother. A Roman Catholic, she and the children attend church regularly but her husband, nominally Church of England, 'can't be bothered with religion'.

Father is a bricklayer by trade and has been frequently unemployed mainly due to self imposed changes in employment in an attempt 'to better himself'. During the past four years he has operated a travelling shop supplying groceries to newly built housing estates and although his trade is flourishing at present it cannot be regarded as a secure

long term prospect. He is a rather unfeeling but well intentioned man, slightly hypomanic, and with little foresight. Although in many ways a kind father he has little sympathy with the children.

38. MASTURBATION

(1) Habitual manipulation of gentalia, at least three of four times per week.

(2) Manipulation once or twice per week or more frequent habitual touching.

(3) Manipulation once or twice per month associated with considerable tension.

4 Occasional handling of gentalia.

5 No overt behaviour or tension.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	2	0	0	0	0	0
(2)	2	0	0	0	1	0
(3)	1	0	0	0	0	0
4	3	0	2	0	0	0
5	68	50	57	46	14	7
6	5	2	1	1	0	0

Numbers too small to justify X^2.

	BOYS%	GIRLS%	TOTAL
Maladjusted group	6.6	NIL	4.0
Control group	NIL	NIL	NIL
Population estimate	1.4	NIL	0.8

MASTURBATION

In Ackerson's (1931) study, 24% of boys and 11% of girls had a history of masturbation but this is probably a reflection of the wide age distribution of his series. McFarlane et al (1954) reported masturbation in only 4% of boys and no girls at the age of eleven. Levine and Bell (1956) consider masturbation a widespread normal habit which should only be regarded as abnormal if the "activity is repeated with such frequency during the waking hours that most other activities are excluded".

In the present study only five boys, all members of the maladjusted group had active symptoms, five boys and two girls from the maladjusted group were no longer active but had previously had symptoms and had one girl and one boy from the control group were regarded as previously showing symptoms.

The only significant intersymptom correlation was of 0.210 with physical timidity.

Illustrative Case

At the age of nine years Bernard developed a habit of scratching and pulling at his genitalia and his mother noticed that he was having frequent erections. She thought that this must indicate a need for circumcision and took the boy to the family doctor who

assured her that there was nothing wrong apart from a habit which would pass if ignored. Since then however the habit continues unabated and the boy's underclothes are often damp due to ejaculations. Bernard stops handling himself when told to do so but is quite unabashed when attention is drawn to his habit.

Apart from excessive crying during the first three months of life Bernard was no trouble until he spent a period of seven weeks in a residential nursery at the age of three years. He was in the nursery whilst his mother was in hospital for an operation and on admission he was a normal boistrous toddler. On discharge he refused to walk, could hardly talk and when he did so he used baby talk with a marked stutter. He gradually learned to walk again 'just like a baby' and his speech became normal within six months.

At the age of four years he spent one week in hospital for removal of his tonsils and adenoids apparently settling quite well but on discharge he was irritable and had frequent temper tantrums.

He settled quite well on starting school but following the birth of his sister when he was five and a half years old his behaviour regressed. At home he refused to feed himself and had to be spoon fed, he began to soil his trousers, and resented any attention his mother gave to the baby. These symptoms gradually settled over the course of a year but he remained bad tempered and developed eye blinking and a nervous cough.

At the age of ten years he was involved in a road accident and sustained a traumatic pneumothorax leading to a three week stay in hospital. This experience did not appear to upset him and he is said to have enjoyed his period in hospital. At present he is a restless, overactive boy, unable to sit still ~~—~~ even when apparently enthralled by his favourite television programme, he persistently blinks his eyes and has a nervous cough. He plays normally with other children and appears to have many friends but is overadventurous and inclined to be foolhardy. Although he doesn't often lose his temper he can be violent in a rage and his mother is afraid that he will seriously hurt someone during an outburst.

Nothing is known about Bernard's father, who left his wife during the fifth month of pregnancy, and his mother is something of an enigma. She gets no allowance from her husband who divorced her six years ago and her own earnings have been irregular and inadequate. When Bernard was born she lived in a single room in a tenement house which was under police surveillance as a suspected 'disorderly house'. She went out to do daily domestic work leaving the infant in the care of a neighbour. When Bernard was five and a half years old she had an illigitimate daughter and gave up working, shortly afterwards moving into a modern council flat. Though she has not worked since the flat is simply but adequately supplied with

furniture including the inevitable multi channel television set, and is always clean and well cared for. The family always have adequate, well cooked meals and is clean and neatly dressed. She appears to be a capable mother but avoids discussing her feelings or personal affairs.

39. SEX INTEREST

(1) Persistent preoccupation and tension regarding sex matters with overreaction to normal situations.

(2) Some tension but less preoccupation than (1).

3 Transient tension, embarrassed by any discussion on sex matters including pregnancy, getting married, etc.

4 Interested in getting married, having children, etc., but a naive interest without tension.

5 No tension or interest.

6 Previous symptoms.

CATEGORY	MALADJUSTED		CONTROL		MAL./CONT.	
	BOYS	GIRLS	BOYS	GIRLS	BOYS	GIRLS
(1)	0	0	0	0	0	0
(2)	0	0	0	0	0	0
3	2	1	1	0	2	0
4	8	16	6	12	2	3
5	66	33	52	54	11	4
6	0	0	0	0	0	0

SEX INTEREST

None of the children in the study exhibited any overt interest in sex matters sufficient to cause any anxiety. Three of the maladjusted group, one of the controls and two from the maladjusted control group were easily embarrassed by discussion of sex and related matters but were not regarded as unduly disturbed in this respect. One of these children, a boy from the maladjusted group, was on one occasion found in a woodshed undressing a female toddler but he explained that they 'were just playing' and has been given the benefit of the doubt.

Alleged sexual interference.

Six of the children in this study (2.3%) of the group have been victims of actual or attempted sexual assault. In none of them has this been regarded as an aetiological factor in any behaviour disturbance, and all appeared to escape more than a transient upset.

Four of the girls were members of the maladjusted group, the only boy a member of the maladjusted control group, and one girl was from the control group.

The latter was accosted at the age of ten years by a man who tried to persuade her to walk with him to a nearby park. She was

afraid of the man and was persuaded to walk as far as the park gates but there saw a group of friends and found courage to run away.

The boy in this group is a solitary unhappy youngster with severe behaviour problems. His father, at present in the regular army, has been away from home most of the boy's life and his mother is under treatment for depression. For several years his mother has taken in boarders and one of them had always taken a great interest in the boy and often entertained him in his room. When the boy was ten years old he was found in the man's room practicing mutual masturbation. The boy was regarded as an innocent victim and the man prosecuted and goaled.

Of the four girls, one was assaulted by a neighbour at the age of seven years but both she and her family were little disturbed by the incident. Another girl, at the age of ten years, was taken with a group of playmates into a neighbour's house where the twenty year old mentally defective son of the household interfered with their clothing. The third girl was followed home from school by a maldeexhibitionist who kept exposing himself and the fourth was saved by the appearance of passers by as a stranger was trying to pull her into his car.

Although these figures are small they suggest, if all the

children in the study are included, that over two per cent of children aged eleven years have been victims of some form of sexual assault. However, five of the six children involved were regarded as maladjusted before the assault occured and it seems probable that these children are particularly vulnerable. The four girls were all attention seeking rather uninhibited children and the boy, disturbed and deprived, found in the man who assaulted him warmth and companionship.

SPEECH DISORDERS

In planning this study, speech disorders were not regarded as manifestations of maladjustment but the findings warrant their inclusion as symptoms. Apart from stuttering, no attempt has been made to slassify the speech defects but all were severe enough to warrant referal for speech therapy at some time. Children with a stutter have been included in the figures for speech defect but are also considered separately.

	Maladjusted		cobtrol		Mal./Cont.	
	Boys	Girls	Boys	Girls	Boys	Girls
Speech disorder before age 5 yrs.	24	6	5	0	5	1
Speech disorder persisting after 5 yrs.	17	6	1	0	2	0
Speech disorder commencing after 5 yrs.	5	3	2	0	1	0
Stutter commencing before 5 yrs.	9	2	2	0	1	0
Stutter commencing after 5 yrs.	2	2	2	0	0	0

Speech defect at any time

Mal. vs Contr.
$X^2 = 18.8$ $P<0.001$

Stutter at any time.
$X^2 = 4.0$ $P<0.05$.

Defect	Maladjusted			Control			Population Estimate		
	Boys %	Girls %	Total %	Boys %	Girls %	Total %	Boys %	Girls %	Total %
Defect before 5 yrs.	31.6	12.0	23.8	8.5	NIL	4.8	13.5	1.9	8.7
Persisting after 5 yrs.	22.4	12.0	18.3	1.7	NIL	1.0	4.1	NIL	2.4
Commencing after 5 yrs.	6.6	6.0	6.4	3.4	NIL	1.9	4.1	NIL	2.4
Stutter commencing before 5 yrs.	11.8	4.0	3.2	3.4	NIL	1.9	4.1	NIL	2.4
Stutter commencing after 5 yrs.	2.6	4.0	3.2	3.4	NIL	1.9	2.7	NIL	1.6

In the maladjusted group thirty children (23.8%) had speech disorders before the age of five years, of these twenty four were boys, including nine with stuttering, and six were girls, including two with a stutter. There was a marked excess of boys over girls in the maladjusted group. In Seventeen of these boys and all six of the girls the disability continued after starting school. Five byys, two with a stutter, and three girls, of whom two had a stutter, developed sppech disorders after the age of five years.

Only boys were affected in the control group.

In five including two with stutters their speech difficulty began before the age of five years and in all but one it has cleared up before starting school. Only two boys developed a speech defect, in both cases a stutter, after starting school.

The difference between the maladjusted and control groups is very striking ($X^2 = 18.8$ $P<0.001$) and suggests a strong association between speech defect and maladjustment. It is of interest that though the association is shown between stuttering only and maladjustment ($X^2 = 4.0$ $P<0.05$) it is likely that this particular defect makes only a small contribution to the total association.

In view of the importance of this group, it seemed worthwhile attempting to make a population estimate and this is shown in table. Although the figures are small, they suggest that 11% of this sample population have had speech defects and that approximately one half of these children were maladjusted. Karwin (1934) in a group of 100 maladjusted children found twice the number of speech defects of all kinds, including stuttering, delayed speech, and lisping, that were found in a comparable group of well adjusted children. Eisenson (1942) in a study from Brooklyn College compared a group with defective speech and a normal control group using the Bernreuter Personality Inventory and found that children with defective speech were more nemrotic, more introverted, and less self confident than normal speakers.

Despert (1946) made an intensive study of fifty stuttering children and found that the majority showed other symptoms of maladjustment and that most of them had made a poor social adjustment before the development of a speech handicap. (Wood 1946) in a study of functional articulatory defects in children found evidence of unfavourable home conditions and emotional maladjustment of the parents, particularly mothers, and concludes that such defects '.... are definitely and significantly associated with maladjustment and undesirable traits on the part of the parents, and that such factors are usually maternally centred.'

An association between speech defect and maladjustment has been clearly established and the present study suggests that a high propottion of children seen in Speech Therapy Units are likely to be maladjusted. In view of this there is clearly a real need for close liason between such units and general paediatric and child psychiatric services.

ABDOMINAL PAIN AND HEADACHE

Among a group of unselected children questioned in school Apley and Naish (1959) found that one child in every nine had "experienced at least three attacks of abdominal pain, severe enough to modify the child's activities or appearance." In comparing these "little bellyaches" against children without pains they found no physical or intellectual differences. In emotional aspect however the children with recurrent abdominal pain were often indrawn and overconcientious and 'usually they show evidence of emotional disturbance'. Apley (1958) found similar associations with headache and limb pains.

In the present study and using the same criteria, the frequency of both abdominal pain and headache was higher than found by Apley. With both symptoms the incidence was higher in the maladjusted group, but not significantly so despite a strong clinical impression that these symptoms were almost universally emotional in origin.

Abdominal pain was an even more widespread symptom, again only pain not associated with other illness was accepted and then only if attacks had occured at least four times. Forty (31.8%) children from the maladjusted group and twenty four (22.9%) of the controls had complained of episodes of abdominal pain. Again the difference

between the two groups is not statistically significant.

In many of these children the pain was clearly related to stress or anxiety and parents referred to 'his nervous tummy' or commented 'he only gets it when he doesn't want to go to school'. Others, usually with little evidence to support their assertions, related the pain to constipation or overeating.

A complaint of recurrent headache, not associated with other illness and for which no organic cause had been found was reported in 31 (24.6%) of the maladjusted group and 22 (21%) of the control group. The difference between the two groups is not statistically significant.

In most cases the child had complained of headaches only in the past two or three years. Several were seen by opticians, opthalmologists, and ear, nose, and throat surgeons, some had been prescribed glasses and other had undergone antral washouts. None of the children suffered severe disability as a result of headache and in no case was the history typical of migraine.

	Maladjusted		Control		Mal./contr		
	Boys	Girls	Boys	Girls	Boys	Girls	
Headache	19	12	10	12	3	1	Mal.vs Cont. X^2= 0.25 N.S.
Abdominal Pain	23	17	9	15	5	3	Mal.vs Cont. X^2= 1.8 N.S.

CONFLICT WITH THE LAW

None of the girls in the study had been in trouble with the police but in the maladjusted group, six boys were the subject of probation orders and ten had been visited at home by the police because of various offences for which they were not actually prosecuted. Of the control group one was subject to a probation order and seven had been visited by the police (X^2 for difference = 1.1, not significant)

It is now possible, having considered in detail the symptom ranges to consider the validity of the terms 'maladjusted' and 'control' as applied to the groups in this study. The maladjusted group was selected on the basis of existing records of a substantial episode of disturbed behaviour based on repeated complaints frm the mother or recorded observations by members of the team. The control group was a one in six sample of the Thousand Families Survey, from which these children already ascertained as maladjusted were then removed, thus forming a small overlap group, the maladjusted/control group.

When the data on each child in this study was complete, a clinical assessment was made and each child rated as severely disturbed, moderately distnrbed, or within normal range. The last category included children with transient upsets, isolated symptoms, or symptoms which their parents regarded as abnormal but which would be accepted by most paediatricians as a normal phase of development. Of the fifty one children (34.5%) from the maladjusted and maladjusted/control group who were regarded as moderately or severely disturbed before the age of five years only ten were classified as 'within normal range' at the age of eleven years.

Those children who were included in the maladjusted group on the basis of behaviour disturbance occurring before their fifth birthday were given two ratings, one based on their recorded behaviour before their fifth birthday and the other on their clinical state at the time of this investigation.

The results of these ratings are shown in Table A (p.251) Comparing final assessments in the maladjusted and control groups, if 'within normal range' is contrasted with 'moderately' and 'severely disturbed' $X^2 = 56.1$, with one degree of freedom, though statistical methods are hardly required to demonstrate so great a difference.

Thus on clinical assessment the two groups are significantly different, the maladjusted group embracing the majority of disturbed children.

Further justification of the grouping can be obtained by consideration of the difference in symptom incidence between the two groups In every symptom considered there has been a true excess of occurrence of the symptom in the maladjusted group and in all but six of the symptoms this difference has been shown to be statistically significant. (See appendix IV)

Thus the evidence once again supports the contention that the children in the maladjusted group are, as a group, maladjusted whilst those in the control group are relatively free from symptoms of

maladjustment. It is therefore suggested that in a representative sample of children from a Northern industrial town 19.4% of childrem, by the age of eleven years have manifested signs of behaviour disturbance beyond the accepted range, that one child in five shows evidence of emotion maladjustment.

These observations may be contrasted with the statements made by the mothers of the children. Each mother was asked whether she had ever regarded her child as emotionally disturbed or troubled with nerves or behaviour problems to such an extent as to cause anxiety within the family. No attempt was made to evaluate these replies so that answers such as 'Yes, he used to wet the bed' or 'He has always been highly strung' were accepted as affirmative. The mother was then asked if she had ever sought advice and, if so, from whom.

	Maladjusted	Control	Mal/Cont.	Severe	Population Est.%
"Emotionally disturbed	92	38	17	67	43.3
No emotional problems	34	67	5	19	56.7
Advice sought	46	6	8	37	11.0
From general practitioner	22	2	3	16	3.9
From specialist (other than psychiatrist)	25	0	3	19	2.4
From psychiatrist	7	0	2	8	1.6
From non medical sources only.	0	4	1	1	0.8

Seventy three per cent of the maladjusted group and 78.4% of the severely maladjusted group were regarded by their mothers as having been emotionally disturbed as against 36.2% of the control group. A population estimate (control plus maladjusted/control group) suggests that 43.3% of the total population were regarded as emotionally disturbed at some time during their first eleven years. Half of those from the maladjusted group and over half (55.2%) from the severely maladjusted group were taken to someone for advice. Whereas in the control group advice was sought in respect of only 15.8% of children regarded as disturbed. This may indicate that the disturbance in the children of the control group was usually transient or easily manageable.

Of those who sought advice (disregarding the control group) less than half approached their general practitioner and more than a quarter of theose who did so were refered on to a paediatrician. In no case was a child refered to a psychiatrist by his family doctor. The remainder sought advice from school medical officers, private specialists, or from specialists to whom the child had initially been refered for advice on a physical illness.

	Maladjusted	Control	Mal/Control	Severe
Advice sought from general practitioner	22	2	3	16
Referred by practitioner to paediatrician	6	0	1	5
Advice sought from non psychiatric specialist	19	0	2	14
Referred by specialist to psychiatrist	2	0	0	2
Advice sought from psychiatrist	5	0	2	6

MALADJUSTED GROUP TOTAL: 126 CHILDREN

BOYS: 76

	Assessment Before 5 Yrs.	Assessment At 11 Years	
Maladjusted before age 5 Yrs. Total: 32	Within normal range 4	Within normal	: 2
		Moderate	: 1
		Severe	: 1
	Moderate disturbance 8	Within normal	: 3
		Moderate	: 3
		Severe	: 2
	Severe disturbance 20	Within normal	: 0
		Moderate	: 6
		Severe	: 14

Maladjusted only after age 5 yrs. 44	Within normal range	: 3
	Moderate disturbance	: 18
	Severe disturbance	: 23

GIRLS: 50

	Assessment Before 5 Yrs.	Assessment At 11 Years	
Maladjusted before age 5 yrs. Total: 22	Within normal range 5	Within normal	: 4
		Moderate	: 1
		Severe	: 0
	Moderate disturbance 8	Within normal	: 5
		Moderate	: 2
		Severe	: 1
	Severe disturbance 9	Within normal	: 0
		Moderate	: 1
		Severe	: 8

Maladjusted only after age 5 yrs. 28	Within normal range	: 5
	Moderate disturbance	: 13
	Severe disturbance	: 10

CONTROL GROUP TOTAL: 105 CHILDREN

Boys: 59		Girls: 46	
Within normal range	36	Within normal range	34
Moderate disturbance	20	Moderate disturbance	10
Severe disturbance	3	Severe disturbance	2

MALADJUSTED/CONTROL GROUP TOTAL: 22 CHILDREN

BOYS: 15

	Assessment before 5 yrs	Assessment at 11 years	
Maladjusted before age 5 yrs.	Within normal range 2	Within normal	: 0
		Moderate	: 0
		Severe	: 2
	Moderate disturbance 1	Within normal	: 1
		Moderate	: 0
		Severe	: 0
	Severe disturbance 3	Within normal	: 0
		Moderate	: 1
		Severe	: 2

Maladjusted only after age 5 yrs. 9	Within normal range	1
	Moderate disturbance	2
	Severe disturbance	6

GIRLS: 7

	Assessment before 5 yrs	Assessment at 11 years	
Maladjusted before age 5 yrs.	Within normal range 0	Within normal	: 0
		Moderate	: 0
		Severe	: 0
	Moderate disturbance 1	Within normal	: 0
		Moderate	: 0
		Severe	: 1
	Severe disturbance 1	Within normal	: 1
		Moderate	: 0
		Severe	: 0

Maladjusted only after age 5 yrs 5	Within normal range	0
	Moderate disturbance	1
	Severe disturbance	4

Table A.

PART THREE

THEIR ENVIRONMENT AND EXPERIENCE

In this section, the background and experience of the children will be discussed. Again, the three study groups of maladjusted, control and maladjusted/control (overlap group) will be considered separately. Comparison will be made mainly between the maladjusted and the control groups but a further division will be introduced i.e. the "severe group".

It seemed advisable to attempt to determine whether or not possible aetiological factors in maladjustment were associated with severity of disturbance. With this in view, the statistics for all children considered at any time to have been severely disturbed were collected together and examined. The severely disturbed group is made up of sixty boys and twenty eight girls drawn from all three of the groups of the study.

THE PRENATAL ENVIRONMENT AND EARLY EXPERIENCE.

Pasamanick (1956) and his colleagues introduced the concept of a 'continuum of reproductive casualty' as a race or group 'fertility regulator'. They suggest that many disabilities including behaviour problems, epilepsy, cerebral palsy, and mental deficiency are the result of pre-natal factors, sub-lethal expressions of the 'fertility regulator'. Stott (1956, 1957, 1958) has developed the argument with accounts of mental retardation, maladjustment, and congenital abnormality following disturbed pregnancy. He lays considerable emphasis on the aetiological importance of psychic stress during pregnancy and includes amongst the results of disturbed pregnancies an excess of early ill health in the infant (excluding epidemic illness).

Pearson (1931) also relates unhappy or mentally disturbed pregnancy and feeding regimes to personality development but regards adverse effects as due to the influence of poor parental adjustment, rather than prenatal experience. Similarly, Fries (1937) suggests that the psychological development of children can be traced from the beginning of pregnancy, in terms of the mothers reaction to the pregnancy. She regards the psychological events of the pregnancy and the neonatal period as predictive of later mother child relationships and believes that any adverse results can be modified by psychiatric treatment.

In the present study, contemporary records were available on labour and the neonatal period with, in many cases, full ante natal records. It was, therefore, possible to verify statements made by the mothers regarding their pregnancy. Such corrections as have been made were largely in matters of detail; the expression 'kidney trouble' for instance, was used by several mothers to describe toxaemia of pregnancy, normal frequency of micturition, cystitis, pyelitis, essential hypertension and backache.

All those mothers who were recorded as having vaginal bleeding during pregnancy reported the fact at interview and no bleeding was reported that was not already recorded. Vague descriptions of labour, 'I had a terrible time', 'It was a very difficult birth', were commonly reported, and were in most cases associated with an objectively reported normal labour and delivery. These cases were recorded in the present study as 'normal labour with complaint'.

Mental stress during pregnancy was not generally recorded at the time so that the mothers' statements had to be accepted. However, only

'serious upsets' or 'prolonged nervous strain' were accepted. The former category included shock in an accident, sudden death of a close relative, sudden desertion by the husband etc., whilst the latter included prolonged absence of the husband, serious financial difficulties, living under threat of eviction, illegitimate pregnancy, 'nervous debility', etc.

The total number in each category is shown in the table below. Item 3, operative delivery, included all breech deliveries and multiple births. Physical illness during pregnancy, item 5, includes all conditions not directly related to the pregnancy which caused disability, and required treatment by the doctor.

	Maladjusted	Control	Maladjusted/ Control	Severe	
1. Normal delivery.....	92	80	18	66	
2. Normal delivery with complaint.	12	13	2	7	
3. Operative delivery.....	22	12	2	14	
4. Toxaemia of pregnancy.....	3	3	1	4	
5. Physical illness during pregnancy.....	32	20	3	20	
6. Bleeding during pregnancy.....	2	1	1	1	
7. Psychological stress during pregnancy.....	43	18	9	43	*
8. Mature infant.....	122	100	21	85	
9. Premature infant.....	4	5	1	3	
10. Health of infant during neonatal period good.....	113	97	22	81	
11. Health of infant during neonatal period indifferent....	9	7	0	4	
12. Health of infant during neonatal period poor.....	4	1	0	3	

* Only statistically significant differences in table.
Maladjusted versus Controls $X^2 = 6.6$ $P<0.01$
Severe versus Controls $X^2 = 21$ $P<0.001$

The only statistically significant differences are within the item of psychological stress during pregnancy. There is no evidence of an excess in the maladjusted group of toxaemia of pregnancy or other 'non-mechanical' complications of pregnancy such as recorded by Pasamanick (1956), Stott (1957) whilst supporting the main contentions of the American workers, laid greater stress on the importance of psychological trauma and the present evidence might be regarded as substantiating his emphasis. However, it is unfortunate that the one factor not clearly described in contemporary records should be incriminated, for the possibility of elaboration over the years cannot be eliminated. The mother of a maladjusted child may well project her anxiety about him back to the pregnancy. A mother unhappy during her pregnancy, perhaps an unwelcome one, could reject her child and the poor mother-child relationship lead to maladjustment. Subjective statements regarding mental well being during pregnancy must also be related to the general mental health of the mother which, as will be demonstrated in a later section, was significantly different in the control and maladjusted groups.

Early illness in the child is regarded by Stott (1959) as an essential part of the 'continuum of reproductive casualty', affected children suffering a disproportionate amount of 'non epidemic' illness, especially pneumonia, during the first five years of life. In the present study two statistics are readily available, the total number of respiratory

infections[1] in the first five years of life and the total number of severe respiratory infections[1] during the same age period. In neither case is any statistically significant difference discernable between the maladjusted or severely maladjusted groups and control group.

Interpretation of this data must be speculative but no association has been demonstrated between physical complications of pregnancy or early illness in the infant and subsequent maladjustment. The high incidence in the maladjusted group of psychological stress during pregnancy is explicable in terms of the mothers personality and poor mother child relationships and some support of this explanation will be found when these factors are examined at a later stage. It would thus appear that the evidence presented in this study does not support the concept of continuing reproductive casualty.

Infant Feeding.

	Maladjusted	Control	Maladjusted/Control	Severe	
Breast Fed..	30	30	5	19	(Maladjusted versus Control X^2 0.47 N.S. (Severe versus Control X^2 0.9 N.S.
Weaned before one year....	61	69	14	43	(Maladjusted versus Control X^2 5.3 P<0.05 (Severe versus Control X^2 5.3 P<0.05
Feeding Problems.....	15	3	2	11	(Maladjusted versus Control X^2 = 6.3P<0.05 (Severe versus Control X^2 = 4.9P<0.05

[1] Total respiratory infections include severe colds causing constitutional disturbance, tonsillitis, bronchitis, pneumonia, and unclassified respiratory disease. Severe respiratory infections comprise bronchitis and pneumonia only.

According to MacKeith (1955) a large proportion of the infant feeding problems which are not due to hunger, are caused by emotional difficulties. Other workers have gone further and suggested that early feeding problems are a portent of later behaviour difficulties. Childers and Hamil (1932) examined a large group of problem children and concluded that undesirable behaviour occurred most frequently among children who were weaned, from breast or bottle, between the ages of one month and six months, with the next greatest frequency in those children who had never been breastfed. The group in which breast feeding had continued for more than eleven months had fewest undesirable traits. In another group of children attending a child guidance clinic Rogerson and Rogerson(1939) found a strong positive association between feeding difficultiesin infancy and psychological difficulties at school age.

In the present study breast feeding was recorded only if continued for at least one month, weaning was recorded as before or after one year and was taken to mean that the infant had ceased feeding from the breast and/or bottle. Feeding problems were recorded in this study if they had been reported as such by the health visitor. Breast feeding was commoner in the control group (28.6%) than in the maladjusted (23.8%) or severe (21.6%) groups but the differences were not statistically significant. Weaning before one year was recorded in 65.7% of the control group, 48.4% of the maladjusted group and 48.9% of the severe group a statistically significant difference. Feeding problems, in connection with breast or bottle feeding occurred in three of the control group, eleven of the

severe group, and fifteen of the maladjusted group and again these differences are statistically significant.

Toilet Training.

A great deal has been written, particularly in the psycho-analytic literature on the hazards of toilet training. However, Dimson (1959) was unable/to demonstrate a relationship between the age of beginning toilet training and later enuresis, but regarded resistance to training as an important aetiological factor. In a comparison of children from "wet" and "dry" families seen in a paediatric out-patient department, he found the age of commencing toilet training similar in both groups, 30% began training under the age of three months, 42% between three and nine months, and 28% after the age of nine months.

In a national survey Douglas and Blomfield (1954) found that, on the whole,children trained early gained sphincter control earlier and were less likely to relapse than children whose toilet training was delayed. Enuresis, particularly in girls, was commoner in later trained children. They found that 60% of infants were "potted" regularly during the first month of life, 24.8% between one and six months and 15.2% after six months.

The age of starting toilet training, that is regular "potting" rather than short trials, was recorded in the present study and the distribution was as follows:

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Established toilet training before three months.....	79 (62.7%)	70 (66.7%)	13	51 (57.9%)
Established between three and twelve months.....	36 (28.6%)	26 (24.8%)	5	29 (32.9%)
Established after twelve months.....	7 (5.6%)	8 (7.6%)	3	5 (5.7%)
Not recorded.....	4 (3.1%)	1 (1%)	1	3 (3.4%)

There is clearly no association in this study between the time of starting toilet training and later behaviour difficulties. The numbers in each class differ from Dimson's group but agree well with the findings of Douglas and Blomfield (1954).

When early difficulties in toilet training are considered a clear association with maladjustment is found. Such difficulties were mainly experienced as resistance to training, for example, the infant who screamed when held on his potty, and was often held there despite resistance but who 'deliberately held on' to his offering until removed from the potty. Difficulties of this kind were recorded in seven of the control group, twenty five of the maladjusted ($X^2 = 7.3$ $P<0.01$), and eighteen of the severe group ($X^2 = 7.0$ $P<0.01$).

Later difficulties, that is problems of excretion developing after a period of established sphincter control, were even more clearly associated with maladjustment. Here however the difference is more artificial as such difficulties are likely to have been important factors in the child's inclusion in the maladjusted group. In the control group twelve children

were recorded under this heading as compared with fifty-one children in the maladjusted group (X^2 = 23 $P<0.001$) and thirty-six children in the severe group (X^2 = 20.8 $P<0.001$).

SEPARATION EXPERIENCE.

In his study of "Forty-four Juvenile Thieves" Bowlby (1946) outlined his concept of the affectionless character resulting from deprivation of maternal care due to separation from mother in the first few years of life. Later, under the auspices of the World Health Organisation, he undertook a review of all the literature on the adverse effects of maternal deprivation (Bowlby, 1951) and concluded that what is "essential for mental health is that the infant and the young child should experience a warm, intimate, and continuous relationship with his mother (or permanent mother substitute) in which both find satisfaction and enjoyment." Bowlby and his co-workers, notably Robertson (1958) have done much to popularise this theory and it is now widely held that a child's personality may be damaged by separation from his mother in infancy or by maternal rejection. Although supporters of the 'Bowlby school' have often been over-enthusiastic in stating their case, this concept has led to greater understanding of the needs of children, particularly those children deprived of a normal home life (Balls, 1958).

There are however some dissenting voices. Barbara Wootton (1959) considers that research into the effects of maternal deprivation is of value chiefly (perhaps only) for "its incidental exposure of the prevalence of deplorable patterns of institutional upbringing, and of the crass indifference of certain hospitals to childish sensitivities." Stott (1955)

believes that separation of mother and child does not have the dire effects supposed. Howells and Layng (1955) were unable to demonstrate any differences in separation experience between a group of maladjusted children and a group of healthy schoolchildren and suggested that most disturbed children suffer emotionally from being with their parents. In her Mersham study, Lewis (1954) found separation a factor in disturbed behaviour, only when the separation was lasting and began before the age of two years. Holman (1953) found also that separation had adverse effects only when it was early and permanent, and emphasised that in her study, separation from father appeared to be as important as maternal deprivation.

In evaluating the views of the so called Bowlby school it is as well to remember that though Bowlby has done much to disseminate these beliefs, the results of maternal deprivation were well known to clinical observers at least a generation ago. Spence, whose views were well summaried in "The Purpose of the Family" (1946), many years ago emphasised the emotional dangers of hospital admission and in 1926 was instrumental in establishing the Newcastle Babies' Hospital for the admission of sick children with their mothers. Ripin (1933), another early worker in the field, compared the development of infants in institutions with those in homes of poor socio-economic status and found that regardless of poverty the infants receiving home care developed more normally than those in institutions. When Bowlby wrote his monograph he found a wealth of supporting evidence in the literature including careful studies by Shirley and Poyntz (1941), Goldfarb (1943), and Spitz (1945, 1946).

Several aspects of separation have been considered in the present study, including separation from either parent, hospital admission, nursery attendance and the fact of mothers working outside their own homes. Separation from mother and father, otherwise than as a result of hospital admission, is treated separately, and age at first separation, total duration of all separations and standard of care during separation are examined. Any separation of over forty eight hours has been recorded. Care during separation was regarded as satisfactory when the child was cared for in his own home by someone known to him, during planned holidays and visits to familiar relatives. Unsatisfactory care was recorded for all admissions to institutions, when the child was cared for by distant unfamiliar relatives or friends, for children cared for by unaided elder siblings of school age, for those children who were left with r elatives or neighbours who were frankly resentful of the fact, and in all cases where the separation was permanent.

Separation from Mother.

Actual Numbers.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Separation before age 6 months...	6	2	0	4
Separation six months to one year	4	3	0	2
Separation during second year....	16	8	1	12
Separation during third year.....	7	8	2	8
Separation during fourth year....	9	4	0	4
Separation during fifth year.....	6	5	2	5
Separation from five to eleven years.....	39	31	11	29
Duration less than one month.....	41	40	6	29
Duration one to three months.....	24	12	7	19
Duration over three months.....	21	9	3	16
Care during separation satisfactory.....	58	53	11	43
Care during separation unsatisfactory.....	27	7	5	21

Percentages.

	Maladjusted %	Control %	Severe %
Separation before age five years...	38.0	28.6	39.8
All separation before age eleven years.....	69.0	58.0	72.7

Separation for over one month maladjusted versus controls $X^2 = 3.95$ $P<0.05$

Separation for over one month severe versus controls - $X^2 = 4.44$ $P<0.05$

Care unsatisfactory during separation maladjusted versus controls $X^2 = 6.88$ $P<0.01$

Care unsatisfactory during separation severe versus controls - $X^2 = 6.76$ $P<0.01$

Separation was experienced rather earlier and more commonly in the maladjusted group but most of the differences were not statistically significant. However, separation for longer than one month and unsatisfactory care during separation were concentrated in the maladjusted group, particularly amongst those children rated severely disturbed and these differences are significant.

Separation from Father.

Actual Numbers.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Separation before age 6 months...	12	9	1	10
Separation six months to one year	10	2	1	7
Separation during second year....	14	7	1	6
Separation during third year.....	7	7	0	6
Separation during fourth year....	3	6	2	1
Separation during fifth year.....	5	5	2	4
Separation from five to eleven years.....	25	27	5	18
Duration less than one month.....	20	24	4	14
Duration one to three months.....	16	15	1	10
Duration over three months.....	39	24	7	27
Care during separation satisfactory.....	53	56	8	31
Care during separation unsatisfactory.....	22	7	4	20

Percentages.

	Maladjusted %	Control %	Severe %
Separation before age five years.	40.5	34.3	38.6
All separation before age eleven years.....	60.3	60.0	59.1

Separation before aged 2 years Maladjusted versus Control $X^2 = 4.4$ $P < 0.05$

Separation before aged 2 years Severe versus Control - $X^2 = 2.4$ Not significant.

Care during separation unsatisfactory
Maladjusted versus Control $X^2 = 5.8$ $P < 0.02$

Care during separation unsatisfactory
Severe versus Control - $X^2 = 8.0$ $P < 0.01$

Here the differences between the groups are less marked and statistically significant differences were found in only two factors. Separation from father before the age of two years was significantly more frequent in the maladjusted group than in the control or severely maladjusted groups. In all separations, unsatisfactory care was recorded more commonly in the severely maladjusted and maladjusted groups, than in the control group.

Hospital Admission.

Apart from the significance of hospital admission as a separation experience a great deal has been written on the admission itself (Lenchan, 1953; Spitz, 1945; Bowlby, Ainsworth, Boston, and Rosenbluth, 1956; Robertson, 1958; Platt Committee, 1959). The Newcastle Babies Hospital now has counterparts elsewhere in the country, to which children can be admitted with their mothers and in most areas the decision to admit a child to hospital is not taken lightly. In the Newcastle area children's

wards or units are well established and most sick children are under the direct supervision of a paediatrician, except in specialist units such as ear, nose and throat or orthopaedic departments; even here the services of a paediatrician are usually available if requested.

In the present study only one child, admitted at the age of a few weeks because of a pyloric stenosis, was accompanied into hospital by his mother and this admission has not been recorded in the following table.

Age at first admission, total duration of all admissions, and number of admissions to hospital were considered. No significant differences were found between the study groups in respect of age of admission or total duration of stay. However, comparing either the total number of admissions to hospital or admission to hospital against no admission to hospital, within the three groups, resulted in statistically significant excesses being found in the maladjusted and severely maladjusted groups. Examination of the records suggests that this excess is not due to admission to hospital because of symptoms of maladjustment.

Hospital Admission.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
One hospital admission.....	45	28	7	28
Two hospital admissions.....	19	15	3	16
Three or more hospital admissions.	10	1	3	11
Total duration less than one month	61	40	10	43
Duration one to three months.....	8	2	0	4
Duration over three months.....	4	2	3	7
Age at first admission under six months.....	10	6	2	8
Age at first admission six months to two years.....	7	8	1	6
Age at first admission two years to five years.....	17	10	4	14
Age at first admission over 5 years	37	20	6	25

Total number of hospital admissions Maladjusted versus Control X^2= 7.5 P<0.01
Total number of hospital admissions Severe versus Control - X^2= 13.8 P<0.00
Admitted against not admitted to hospital
Maladjusted versus Control X^2= 5.9 P<0.02
Admitted against not admitted to hospital
Severe versus Control - X^2= 7.4 P<0.01

Nursery Care.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Number of children in nursery at any time.....	25	11	4	22
Duration of nursery attendance less than one month.....	5	1	1	4
Duration of nursery attendance one to six months.....	8	1	0	3
Duration of nursery attendance over six months.....	12	9	3	15
Day Nursery.....	17	11	3	18
Residential Nursery.....	11	2	1	7

Nursery attendance at any time maladjusted versus controls X^2 = 3.2 Not significant.
Nursery attendance at any time severe versus controls - X^2 = 6.2 P<0.02
Admission to residential nursery
maladjusted versus controls X^2 = 3.8 P<0.05
Admission to residential nursery severe versus controls- Numbers too small for X^2

More of the children in the maladjusted and severe groups attended a nursery at some time and their attendances were of longer duration than those of the control group. The excess of children attending nursery at any time was significant for the severe group but not for the maladjusted group. In the case of residential nurseries the excess in the maladjusted group was statistically significant, whilst the numbers in the severe group were too small for formal statistical tests.

Mothers Working Outside Their Own Homes.

After examining the employment record of mothers of a nation wide group of five year old children, Douglas and Blomfield (1954) concluded that "there is no reason to believe that the children of employed mothers are in any way at a disadvantage." Whilst this is at variance with the widely held view that working mothers frequently neglect the physical and emotional needs of their children (Glueck, 1934; Wootton, 1959), it is not an entirely new observation. In a study of delinquency in Glasgow, Ferguson (1952), found no association between delinquency and working mothers and Wootton (1959), in her analysis of twelve studies of delinquency, found no convincing evidence of association: Lewis (1954) was unable to relate behaviour disturbance in her group to the mothers' employment records.

In the present study there was no significant difference between the group in respect of the number of mothers in full time or part time employment. Nor was there any association with the age of the child when the mother began work.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Mother in full time work.....	39	29	3	39
Mother in part time work.....	33	40	8	25
Mother began working before child one year old.....	15	9	3	13
Mother began working before child aged 1-3 years.....	10	21	2	11
Mother began working before child aged 3-5 years.....	8	7	3	6
Mother began working after child 5 years old.....	39	33	2	23

Mother working recorded in all cases of employment outside the home for more than one month.

In summary, some association has been demonstrated between maladjustment and separation from mother for a period of at least one month, or separation from father before the age of two years. However, regardless of the duration or timing of separation from either parent, the circumstances of the separation or the standard of care during such separation appears to be of importance, unsatisfactory care being associated with maladjustment. Hospital admission, regardless of age or duration, is also significantly associated with maladjustment and, though here only small numbers are involved the same holds true of nursery, particularly residential nursery, care. No association has been demonstrated between maladjustment and the employment of mothers outside their own homes.

INTERPERSONAL RELATIONSHIPS.

Parent Child Relationships.

An attempt has been made to assess the quality of the relationship between each child in the study and each of his parents. This is obviously a subjective judgment for which it is impossible to offer a precise definition. In making the assessment an attempt was made to take into account positive features such as parental warmth and acceptance, parent participation in the child's activities, and the ease with which the child related to the parent. On the negative side frank rejection or cruelty, apparent total indifference to the child's needs and interests, and more rarely, gross over-protection were seen and taken into account. In assessing the relationship with the fathers, local culture patterns

were taken into consideration as in this area it is not uncommon for father to be normally rather detached from the children, rarely playing with them or taking them on outings, and leaving their management almost entirely to the mother.

Relationships were assessed as satisfactory, unsatisfactory, or variable. The latter category appeared essential to describe a group of parents with a markedly ambivalent attitude towards their children which varied from indulgence to frank cruelty at different times. When the assessment was in doubt, it was recorded as "not known", a category which was in fact used less often than had been anticipated.

Child's Relationship with Mother.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Satisfactory.	49	77	3	12
Unsatisfactory.	32	8	7	32
Variable.	31	10	7	28
Not known.	14	10	5	16

Comparing satisfactory against unsatisfactory and variable
Maladjusted versus Controls $X^2 = 28.6$ $P < 0.001$
Comparing satisfactory against unsatisfactory and variable
Severe versus controls - $X^2 = 66.1$ $P < 0.001$

The association between unsatisfactory or variable relationship with the mother, and maladjustment, as these terms are defined in the present study, is strikingly demonstrated (X^2 28.6 $P < 0.001$). In the severe group the distinction is even more marked ($X^2 = 66.1$ $P < 0.001$).

Child's Relationship with Father.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Satisfactory.	37	70	5	17
Unsatisfactory.	39	11	9	38
Variable.	15	1	2	8
Not known.	34	23	6	25

Comparing satisfactory against unsatisfactory or variable,
Maladjusted versus Controls $X^2 = 34.9$ $P < 0.001$
Comparing satisfactory against unsatisfactory or variable,
Severe versus Controls - $X^2 = 48.5$ $P < 0.001$

An unsatisfactory relationship with the father is again strongly associated in this study, with maladjustment and with severity of disturbance.

Howells and Layng (1955) suggested that most disturbed children suffer emotionally from being with their parents and that deprivation springs most commonly from inadequate parental care. From her Mersham study Lewis (1954) believes that separation alone is not more harmful than some other kinds of privation and stress. On the other hand there is a powerful body of evidence (Bowlby, 1951) indicating an association between separation from mother and maladjustment, whilst Holman (1954) emphasises that separation from father can be equally harmful.

These views are surely not incompatible. The disturbance in the child and in parent child r elationships caused by separation is a matter of common clinical observation (Spence, 1946). At the same time, disturbed children commonly have disturbed parents. It seems probable that the fundamental problem in most maladjusted children is a defect in personal relations with their parents and one factor in such defective relationships may be separation under certain circumstances.

Burt and Howard (1952) reject the view that 'the primary causes of maladjustment are to be found within the individual and in the structure of his relations with the rest of the family...' but it is difficult to do so on the evidence of the present study.

Sibling Relationships.

An attempt was made in this study to obtain an estimate of inter-sibling relationships but this proved impossible. Mothers were unable or unwilling to indicate which were for the index child, favourite siblings and were extremely reluctant to suggest that any of their children did not get on well together. Some indication of marked rivalry was obtained under the symptom heading jealousy, but even here parents were often unwilling to admit to jealousies which by ordinary standards would be accepted as normal.

Marital Relationships of Parents.

Each mother was asked, toward the end of the interview, whether she regarded her marriage as a happy one. In addition an assessment of the marital relationship was made, based on the existing records and my own knowledge of the family.

Mother's Statement of Relationship.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Happy.	89	89	16	52
Average.	17	10	2	17
Unhappy.	17	6	4	17

Happy against average and unhappy Maladjusted versus controls $X_2^2 = 4.4$ $P < 0.05$
Happy against average and unhappy Severe versus controls - $X_2^2 = 13.3$ $P < 0.001$
Happy and average against unhappy Maladjusted versus controls $X^2 = 3.3$ Not significant.
Happy and average against unhappy Severe versus controls $X^2 = 7.6$ $P < 0.01$.

Assessment of Marital Relationship.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Very good.	17	18	0	6
Good.	40	46	7	23
Average.	27	27	8	21
Unsatisfactory.	25	9	6	24
Bad.	16	5	1	13

Very good and good against average, unsatisfactory, and bad
Maladjusted versus Controls $X^2 = 4.8$ $P < 0.05$
Very good and good against average, unsatisfactory, and bad
Severe versus Controls - $X^2 = 13.4$ $P < 0.001$
Very good, good, and average against unsatisfactory and bad
Maladjusted versus Controls $X^2 = 10.8$ $P < 0.001$
Very good, good, and average against unsatisfactory and bad
Severe versus Controls - $X^2 = 19.3$ $P < 0.001$

There is in this study an obvious strong association between marital disharmony and maladjustment of the child and this is most marked among the severely disturbed children.

Non-functioning Families.

Under this heading, any family not functioning as a family unit is considered. In cases in which one or both parents has permanently left the household through death, divorce or desertion this is described as a "broken home". "Family never established" is recorded where the child has never had a father in any sense, for example, the illegitimate child brought up by his mother or relative or cases where the father deserted or died before the child was born. "Tenuous relationships" is the term used to cover a small, but interesting group, in which for a variety of reasons the parents have never lived together except for brief periods. Where for some reason, physical or mental, one or both parents have been unable to contribute towards a normal family life, e.g. they may be chronic invalids confined to bed for many years, the family has been recorded as "not functioning effectively".

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Family never established.....	5	1	0	4
Tenuous relationships.....	1	1	1	3
Broken home.....	14	7	0	9
Home not functioning effectively.....	15	11	3	15

Total indictments maladjusted versus controls $X^2_2 = 2.0$ Not significant.
Total indictments severe versus controls - $X^2 = 7.6$ $P < 0.01$

On these figures there is no association established between these gross family disturbances and maladjustment only, but a clear association with severe maladjustment is shown.

The Grandparents.

Grandparents appear to play an important role in the family structure in urban society (Townsend, 1957) and some attempt was made in this study to measure their influence. Information concerning other relatives was difficult to collect and handle, and consideration will therefore be confined to grandparents.

The available information has been arranged to show the number of families who were in regular contact with the respective grandparents through visits or correspondence and the numbers exchanging visits at least once weekly before and after the survey child was five years old. In the families in which either grandmother was an integral member of the survey family, that is participating daily in the life of the family though not necessarily living with them, and relied upon for moral support or domestic help, this has been reported. Separate categories have also been employed for those instances in which there was excessive

dependence upon, or domination by grandmother or in which the survey child was largely cared for by a grandmother.

	Maladjusted.	Control.	Maladjusted/ Control	Severe.	Population Estimate.
Regular contact with maternal grandparents.....	100 (79.4%)	76 (72.4%)	16	65 (73.8%)	72.4%
Visiting at least once weekly before age 5 years.....	84 (66.7%)	65 (61.9%)	15	54 (61.3%)	63.0%
Visiting at least once weekly after age 5 years.....	73 (57.9%)	55 (52.4%)	13	45 (51.1%)	53.5%
Regular contact with paternal grandparents.....	73 (57.9%)	66 (62.9%)	15	46 (52.3%)	63.8%
Visiting at least once weekly before age 5 years.....	42 (33.3%)	30 (28.6%)	6	21 (23.9%)	28.4%
Visiting at least once weekly after age 5 years.....	41 (32.5%)	24 (22.9%)	6	20 (22.7%)	23.6%

In the main tables, a population estimate (control group plus maladjusted/control group) is given in view of the general interest of this data.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Maternal grandmother integral member of family.....	17	9	6	13
Paternal grandmother integral member of family.....	3	2	0	2
Excessive dependence or domination by grandmother.....	8	1	2	7
Child in care of grandmother (mother living).....	6	0	0	4
Child in care of grandmother (mother dead).....	3	2	0	1

There were no significant differences between the groups in any respect though there is a suggestion that dependence of the family on a grandmother is concentrated in the maladjusted group. If the groups of excessive dependence on grandmother and either grandparent an 'integral member of family' are combined, the difference between the control and maladjusted groups is significant ($X^2 = 4.0$ $P<0.05$). It seems that so far as the families in this study are concerned, contact is best maintained with the maternal grandparents and it is estimated that overhalf of the families in the population continue to exchange regular visits after at least one child is over five years old. Paternal grandparents appear to be seen less frequently but it is not possible at present to show whether this is related to different death rates between the two groups of grandparents. It does however confirm the impression that many mothers continue to look to their own mother for support or companionship after marriage.

THE PARENTS.

Age at birth of Index Child.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Mothers age under 20 years....	6	3	1	6
Mothers age 20-25 years.....	41	21	5	27
Mothers age 26-30 years.....	44	34	5	25
Mothers age 31-35 years.....	22	23	6	16
Mothers age 36-40 years.....	11	17	3	9
Mothers age over 40 years.....	2	7	2	5

Mothers aged under 25 years. Maladjusted versus Controls $X_2^2 = 5.0$ $P<0.05$
Mothers aged under 25 years. Severe versus Controls - $X_2^2 = 6.5$ $P<0.05$
Mothers aged under 30 years. Maladjusted versus Controls $X_2^2 = 4.3$ $P<0.05$
Mothers aged under 30 years. Severe versus Controls - $X^2 = 2.2$ Not significant.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Fathers age under 20 years....	0	0	1	0
Fathers age under 20-25 years.	29	13	3	16
Fathers age 26-30 years.....	40	24	3	27
Fathers age 31-35 years.....	29	30	5	19
Fathers age 36-40 years.....	20	18	5	16
Fathers age over 40 years.....	7	19	5	9

Fathers aged under 25 years. Maladjusted versus Controls $X^2 = 2.2$ Not significant.
Fathers aged under 25 years. Severe versus Controls - $X^2 = 8.1$ $P < 0.01$
Fathers aged under 30 years. Severe versus Controls - $X^2 = 3.2$ Not significant.

A significantly high proportion of mothers of the maladjusted children were under the age of twenty five years at the birth of the index child. The proportion under the age of thirty years is even higher. In the severe group there was an excess of mothers under the age of twenty five years but if the age limit is raised to thirty years the difference is not statistically significant.

The fathers of the maladjusted children also were rather younger than those of the controls and when the age for comparison was taken as thirty years the excess was significant. When the severe group was compared with the control group no significant differences were apparent.

Marital Status at Birth of Index Child.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Married less than one year...	23	13	3	13
Married one to three years...	28	15	2	17
Married four years or more...	61	65	14	48
Cohabiting.....	3	5	1	3
Unmarried.....	4	1	1	3
Duration of marriage not recorded.....	7	6	1	4

Married less than four years. Maladjusted versus Controls $X^2 = 4.5$ $P < 0.05$
Married less than four years. Severe versus Controls - $X^2 = 1.0$ Not significant.

The parents of the maladjusted group had, on the whole, been married for a shorter period than those of the control group at the time the index child was born and there is a statistically significant excess of parents married less than four years in the maladjusted group.

Childhood Experience of the Parents.

Enquiry was made from the mother about the education and childhood experience of both parents. They were asked to say whether their own childhood had been a happy or unhappy one. Those who described their childhood as reasonably happy despite serious family disturbances were recorded as 'doubtful'. In addition, permanent loss of either parent was recorded.

Mothers.

Education.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Elementary school.....	116	95	20	81
Technical or commercial school	3	3	1	1
Grammar school.....	7	6	1	6
Private school.....	0	0	0	0
University..	0	1	0	0

Childhood.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Happy.....	61	71	14	46
Doubtful.....	33	28	4	22
Unhappy.....	25	6	4	18
Not recorded.....	7	0	0	2

Deficiency of 'happy' responses Maladjusted versus Controls
$X^2 = 5.5$ $P < 0.05$
Deficiency of 'happy' responses Severe versus Controls
$X^2 = 3.4$ Not significant.

Loss of Parent.	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Before age 2 years.....	11	6	1	8
Aged two to five years.....	9	8	2	10
Aged six to ten years.....	12	4	2	6
Aged eleven to twenty years...	12	7	1	7

Total loss Maladjusted versus Controls X_2^2 = 2.9 Not significant.
Total loss Severe versus Controls - X^2 = 2.5 Not significant.

Fathers.

Education.	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Elementary school.....	106	97	21	79
Technical or commercial school.....	12	3	1	3
Grammar school.....	6	3	0	5
Private school.....	0	0	0	0
University.....	2	2	0	1

Childhood.	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Happy.....	62	64	10	44
Doubtful.....	30	26	6	18
Unhappy.....	27	15	6	23
Not recorded.....	7	0	0	3

Loss of Parent.	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Before age two years.....	10	7	0	4
Aged two to five years.....	7	6	1	3
Aged six to ten years.....	10	12	1	9
Aged eleven to twenty years.	9	10	1	15

There is an excess of mothers of the maladjusted children who did not regard their childhood as happy but otherwise the differences between the groups are not statistically significant.

Psychiatric Status of Parents.

In a community survey of a Baltimore health district Lemkau, Tietze, and Cooper (1942) studied the prevalence of mental disorders. They concluded that "the lay term 'nervous' is used to cover a multitude of psychiatric conditions but when treated as a residual group after the removal of known psychotics and mental defectives, this group corresponds in the sex and racedistribution pattern to the adult cases diagnosed as psychoneurosis or as having neurotic traits". Downes and Simon (1953) as a result of their own experience in general morbidity surveys, felt it reasonable to conclude that "persons who report chronic nervousness may be properly classed as suffering from a psychiatric condition."

An attempt was made in the present study to estimate the number of parents who suffered from psychiatric disabilities. Information in this field is likely to be incomplete so far as definitive diagnosis is concerned. Where available, information regarding psychiatric in-patient or out-patient treatment has been recorded, as has been a diagnosis of psychiatric illness made by a non psychiatric specialist or general practitioner. In some cases where gross evidence of psychiatric disturbance is recorded incidentally in our case records, this has been indicated as 'other evidence'. Finally, each mother was asked whether she or her spouse was 'troubled with nerves' and, if so, whether the complaint was longstanding. If each question was answered in the affirmative, that parent was recorded under the heading of 'chronic nervousness'.

There is some overlap between the various groups and therefore those parents with no psychiatric complaints are indicated separately.

Mothers.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Psychiatric in patient treatment	2	3	0	1
Psychiatric out patient treatment	8	5	1	6
Other hospital diagnosis	9	2	0	6
General practitioner diagnosis	50	31	10	38
Other evidence	23	9	6	21
"Chronic nervousness"	71	37	14	53
No psychiatric disability	47	64	3	33

No psychiatric disability Maladjusted versus Controls $X_2^2 = 11.9$ $P<0.001$
No psychiatric disability Severe versus Controls - $X^2 = 9.7$ $P<0.01$

Fathers.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Psychiatric in patient treatment	1	1	0	1
Psychiatric out patient treatment	0	2	0	0
Other hospital diagnosis	4	1	1	3
General practitioner diagnosis	3	9	2	5
Other evidence	8	8	5	10
" Chronic nervousness"	15	13	6	12
No psychiatric disability	106	84	14	70

Only 37.3% of mothers in the maladjusted group had no recorded psychiatric disability as compared with 61% of the control group and and 37.5% of mothers in the severe group. There is thus a striking association between complaint of psychiatric disability in the mother and maladjustment in the child.

Psychiatric disability by these criteria was much less common among the fathers in this study and no statistically significant differences were found between the three groups. "No psychiatric disability" was recorded in 84.1% of the fathers of the maladjusted children, in 79.5% of fathers of children in the severe group and 80% of fathers of control group children.

Asocial Behaviour by Parents.

The following table shows no significant differences between the groups:

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Criminal conviction.....	5	5	2	7
Excessive drunkenness.....	10	4	2	6
Cruelty or violence.....	8	2	3	8
Venereal disease.....	3	2	0	2
Excessive gambling.....	1	1	1	2
Chronic unemployment.....	19	22	8	19
Social dependence.....	13	10	2	12
Chronic illness.....	9	13	1	7
Chronic debt.....	9	6	4	11
Promiscuity.....	11	4	1	11
Family history of above listed items.....	12	3	3	6

Family History.

Epilepsy or mental disorder in the siblings, parents, or grandparents of the index child's parents was enquired for and the results are shown below. These disorders in the index child and his siblings are listed separately.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Maternal family history of epilepsy.....	9	8	3	10
Epilepsy in mother.....	4	0	1	4
Fit at any time in index child	17	6	3	13
Fit at any time in sibling of index child.....	8	8	0	5
Paternal family history of epilepsy.....	4	6	0	4
Epilepsy in father.....	3	0	0	3

Although none of the above differences is statistically significant there is a concentration of children who have had convulsions in the maladjusted and severe groups. It is also of interest that of the eight epileptic parents all had maladjusted children and seven of these were in the severe group.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Maternal family history of mental disorder.....	18	9	6	16
Paternal family history of mental disorder.....	14	7	1	8
Behaviour problem in sibling of index child.....	17	12	5	16
Delinquency in sibling of index child.....	8	5	0	7
Educationally subnormal or defective sibling of index child.....	4	5	0	3

Again none of these differences is statistically significant.

Family Size.

Number of Children.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
1	21	14	3	15
2	48	33	3	24
3	18	17	9	18
4	14	13	3	10
5	9	11	2	8
6	8	4	0	5
7	5	3	2	4
8	1	3	0	2
9	2	2	0	0
10	0	4	0	2
11	0	0	0	0
12	0	1	0	0

Mean family size Maladjusted group 3.023 S.D. 12.56.
Control group 3.590 S.D. 18.77
Standard error = 0.524
Maladjusted versus Controls more than 2 in family x^2 = 1.92 Not significant.
Mean family size Severe group 3.3.

There is no significant difference between the groups in respect of family size.

Family Planning.

A number of questions on family planning were included in the study interview and only sixteen mothers declined an invitation to discuss these matters. Of those who answered the questions a number were evidently self conscious and hesitant, therefore detailed supplementary questioning was avoided and the material is presented as recorded.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Birth control never employed..	80 (63.5%)	74 (70.5%)	16	57 (64.8%)
Birth control used regularly..	37 (29.4%)	29 (27.6%)	7	26 (29.5%)
Index child unplanned pregnancy.....	57 (45.2%)	42 (40%)	14	45 (51.1%)
Index child planned pregnancy.	54 (42.9%)	49 (46.7%)	4	32 (36.4%)
Would have preferred a larger family.....	47 (37.3%)	36 (34.3%)	7	32 (36.4%)
Would have preferred a smaller family.....	30 (23.8%)	32 (30.5%)	8	29 (32.9%)

No statistically significant differences between groups.

Sex Education of Index Child.

As with family planning, there is a dearth of information on the extent to which children in our community receive sex instruction. The information obtained in the present study is therefore presented in full although there is no evident association between the quality of sex education and maladjustment. It is presented in this section of the thesis because it is concerned with sex instruction given by parents rather than what the child may have acquired from other sources.

Ramsey (1943) found an advanced level of sex knowledge among ten year old American boys. He found that 69.1% of his sample knew of the mother origin of babies, 57.5% knew about intercourse, 43.2% had learned about masturbation and almost a quarter of the group knew about prostitution by the age of ten years. He found that his own and most similar studies agreed that parents provide their children with very little sex knowledge. Gesell (1946) and Lemkau (1949) believe that the age period 5-10 years affords a good opportunity for sex education because the child is undergoing a period of progressive organisation in self and sex attitudes.

In this study the degree of sex education was recorded as none whatsoever, limited discussion usually confined to answering some of the child's questions, and free discussion in which an attempt was always made to answer the child's questions and in some cases, formal teaching had been attempted. Where girls were concerned, mothers were also asked if the child "knows about her periods" and as this was evidently regarded as

unrelated to sex knowledge this has been recorded separately.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Free discussion....	7 (5.6%)	6 (5.7%)	1	3 (3.4%)
Limited discussion.	18 (14.3%)	12 (11.4%)	1	9 (10.2%)
No discussion.....	101 (80.1%)	87 (82.9%)	20	76 (86.4%)
Periods *	13 (26%)	9 (19.6%)	2	7 (25%)

* percentages here refer to girls only.

It is apparent from these figures that at least four out of five children had received no information on sex from their parents. From the interviews it was equally clear that the majority of these children never would receive any information. A common reply in this section was "I knew nothing when I was married and they'll just have to pick it up like I did ". Several mothers thought that sex knowledge, particularly if sex instruction was to be given at school, would lead to immoral practices. A number of mothers observed a strict taboo on all sex discussion even to the point of refusing to discuss contraception with their husbands. One mother said of sex instruction "We never believed in that sort of thing in our family, I was twenty five years old when I had my first child and I thought the pain was constipation."

Whilst the majority indicated that they had never received any instruction themselves and agreed that this had often led to difficulty or embarrassment, only about a third of these mothers wanted their own children to be better prepared. Many, even of these mothers, felt too embarrassed or inadequate to give the instruction themselves and in any case felt that the children should be 'left in ignorance' until leaving school.

The level of understanding of sex matters, even of simple hygiene and contraception, among the parents of these children would appear to be appallingly low and it seems that this state of affairs is likely to continue into the next generation. It would appear from this study that by the age of eleven years, free discussion of matters concerning sex and full answers to questions are permitted to only one child in twenty whilst even limited information is denied to four out of five children. This must surely have an effect upon the development of the future adult attitudes of these children and may well eventually result in unhappiness and misunderstanding.

Religion.

No significant associations were found between stated religious denomination or relative frequency of worship by the parents and maladjustment in the children. Nor was any assocation found between maladjusted children and religious differences within the family, all such differences as were found being in marriages where only one partner was a Roman Catholic.

Mothers.

	Maladjusted.		Control.		Maladjusted/ Control.	Severe	
Protestant.....	98	(77.8%)	80	(76.2%)	17	67	(76.2%)
Roman Catholic.....	24	(19%)	23	(21.9%)	5	20	(22.7%)
Other.....	4	(3.2%)	2	(1.9%)	0	1	(1.1%)
Regular Churchgoer.....	22	(17.5%)	17	(16.2%)	2	10	(11.4%)
Occasional Churchgoer...	13	(10.3%)	14	(13.3%)	3	8	(9.1%)
Special Events only.....	40	(31.7%)	24	(22.9%)	5	16	(18.2%)
Never goes to Church....	51	(40.5%)	50	(47.6%)	12	54	(61.3%)

Fathers.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Protestant.....	103 (81.7%)	81 (77.1%)	15	64 (72.7%)
Roman Catholic.....	20 (15.9%)	22 (21%)	7	22 (25%)
Other.....	3 (2.4%)	2 (1.9%)	0	2 (2.3%)
Regular churchgoer.....	16 (12.7%)	7 (6.7%)	0	7 (8%)
Occasional churchgoer..	5 (4%)	5 (4.8%)	0	3 (3.4%)
Special events only....	7 (5.5%)	9 (8.5%)	2	8 (9.1%)
Never goes to church...	98 (77.8%)	84 (80%)	20	70 (79.5%)

Index Children.

Protestant.....	105 (83.3%)	79 (75.2%)	17	71 (80.7%)
Roman Catholic.....	18 (14.3%)	23 (21.9%)	5	16 (18.2%)
Other.....	3 (2.4%)	3 (2.9%)	0	1 (1.1%)
Regularly attends church or Sunday School....	70 (55.6%)	66 (62.9%)	9	38 (43.2%)
Intermittent attender..	25 (19.8%)	20 (19.1%)	5	19 (21.6%)
Never attends.....	31 (24.6%)	19 (18%)	8	31 (35.2%)

Never attends Severe versus Controls $X^2 = 6.5$ $P < 0.02$

Religious difference in family.....	29 (23%)	22 (21%)	5	24 (27.3%)

The only statistically significant difference here is that severely maladjusted children are less likely to attend sunday school than the children of the control group.

THE PHYSICAL ENVIRONMENT.

Social Class.

Each family was classified according to the occupation of the father using both the Registrar General's classification and the social groups employed by Douglas and Blomfield (1954). No significant differences emerged, using either method.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Social Class I.....	0	1	1	1
Social Class II.....	10	8	2	5
Social Class III.....	68	54	11	41
Social Class IV.....	20	13	0	15
Social Class V.....	28	29	8	26

Maladjusted versus Controls $X^2 = 1.33$ with four degrees of freedom. Not significant.

Social Group.

A. Professional.....	2	1	0	0
B. Employers.....	2	1	0	1
C. Salaried.....	10	4	0	4
D. Blackcoated.....	7	7	3	5
E. Skilled manual.....	49	48	7	33
F. Semi-skilled.....	38	21	4	24
G. Unskilled manual.....	13	16	4	15
H. Agricultural.....	0	0	0	0
I. Self employed.....	4	1	2	2
Not recorded.....	1	6	2	4

Maladjusted versus Controls. 3 x 2 table for (ABC), (DI), (EFGH)
$X^2 = 1.8$ with four degrees of freedom. Not significant.

Social Status Relative to Grandparents.

The social group of the grandparents was recorded (Appendix 5) and differences in status between parents and grandparents were noted. Again no significant differences were found between the study groups.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Relative to maternal grandparents.				
Social status improved...	24	15	5	15
Social status declined...	26	20	4	18
Relative to paternal grandparents.				
Social status improved...	23	11	3	15
Social status declined...	19	16	3	15

Social trend of Parents in past eleven years.

Social trend up.....	12	3	1	5
Social trend down.....	6	6	4	6

Employment Record of Father.

Fathers in regular employment with few changes of job and then usually in the direction of improvement in hours, conditions, or earnings were regarded as having a stable employment record. Unstable employment was recorded where the father was frequently unemployed and or frequently changed his job without evident improvement in hours, conditions or earnings. At least four separate job changes within the eleven year period were required for inclusion in this group and changes due to the nature of the work (e.g. employment in the building trades) were not regarded as evidence of an unstable employment record.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Stable employment record.....	94 (74.6%)	81 (77.1%)	12	58 (65.9%)
Unstable employment record...	32 (25.4%)	24 (22.9%)	10	30 (34.1%)

The percentage of fathers with an unstable employment record is surprisingly high in all groups but the slight excess in the maladjusted group is not statistically significant.

Income.

Enquiry was made as to total housekeeping allowance and this was divided by the total number of persons in the household, regardless of age, to give the figure 'housekeeping money per head'. Mothers were also asked whether or not they could manage on their present allowance. A substantial number qualified their replies e.g. "Only if I continue to work" or "Only if my husband is on full overtime" and therefore the

replies have been divided into three groups as shown. The mothers were also asked if they knew their husbands' actual wage, though they were not asked to disclose this. A number of the answers to this question were quite surprising, and two mothers did not even know where their husbands worked.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Satisfied with present income.	61 (48.4%)	51 (48.6%)	11	42 (47.7%)
Reservations about present income.....	55 (43.7%)	50 (47.6%)	10	41 (46.6 %)
Not managing on present income.....	10 (7.9%)	4 (3.8%)	0	5 (5.7%)
Husbands wage not known.....	32 (25.4%)	40 (38.1%)	9	20 (22.7%)

Wage not known Maladjusted versus Control $X_2^2 = 3.75$ Not significant.
Wage not known Severe versus Control - $X^2 = 4.6$ $P < 0.05$

Housekeeping per head (Shillings).	Maladjusted.	Control.	Severe.
10 - 19	0	0	1
20 - 29	8	3	7
30 - 39	20	25	17
40 - 49	32	21	19
50 - 59	24	18	17
60 - 69	13	21	9
70 - 79	12	4	9
80 - 89	3	2	1
90 - 99	3	2	2
Over 100	7	9	4
Mean.	£2. 14. 3.	£2. 13.8½.	£2.12.2½.
Standard deviation.	20.1	20.9	19.6

Standard error of difference 2.74.

The only statistically significant difference in this group of data is the excess in the control group over the severely maladjusted group of mothers who did not know their husbands actual wage. Perhaps the emancipation of women is not without its drawbacks.

"The Dwellings"

An example of prewar blocks of flats.

The more characteristic terrace flats are shown on page 14.

Housing.

There were no significant differences between the groups in respect of type of housing but removal was significantly more frequent among the maladjusted and severely maladjusted groups.

Type of House.	Maladjusted.	Control.	Maladjusted/ Control.	Severe
Detached.....	1	0	1	2
Semi-detached.....	7	7	1	6
Self-contained Council house.....	50	39	8	34
Terrace house.....	10	11	1	5
Bungalow.....	1	3	0	0
Prefabricated dwelling....	5	2	1	3
Flat in block.....	17	10	3	13
Flat in house.....	33	30	8	24
Rooms.....	2	3	0	2
Removal to better property	92	64	17	64
Removal to inferior property.....	5	3	0	7

Removed against not removed. Maladjusted versus Controls $X_2^2 = 4.2$ $P < 0.05$
Removed against not removed. Severe versus Controls - $X^2 = 5.9$ $P < 0.02$

Standards of Physical Care in the Home.

Standards in the home were assessed as good, average, or definitely below average. Although there is an excess of good ratings in the control group as opposed to the other groups the differences are not statistically significant.

	Maladjusted.	Control.	Maladjusted/Control.	Severe.
Good.....	61	55	10	35
Average.....	40	35	6	29
Below average.	25	15	6	24

"Good" against other ratings. Maladjusted versus Controls $X^2 = 0.22$ Not significant.
"Good" against other ratings. Severe versus Controls - $X^2 = 2.6$ Not significant.

Overcrowding in the Home.

This has been calculated as number of persons per room in the household.

Persons per Room.	Maladjusted.	Control.	Maladjusted/Control.	Severe.
One or less.....	59	47	8	40
1 -1½.....	39	29	9	28
1½ - 2.....	25	17	4	15
More than two.....	1	9	1	3

More than 1½ persons per room. Maladjusted versus Control $X^2 = 0.42$ Not significant.
More than 1½ persons per room. Severe versus Control - $X^2 = 0.32$ Not significant.

There appears to be a slight excess of overcrowding in the control group but the differences between the groups are not statistically significant.

Sleeping Arrangements.

Douglas and Blomfield (1954) were struck by the high proportion of four year old children who shared their beds. In England and Wales 26% of their group shared a bed and only 29% had their own rooms. They will find little consolation in the findings of the present study for, whilst figures for the state of affairs at age four years are not available, at eleven years the proportion of children sharing a bed is actually higher.

Sleeping Accomodation.	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Own Room.....	45	33	7	37
Own bed, shared room (same sex).....	16	16	2	7
Own bed, shared room (opposite sex).....	7	1	2	4
Shared bed (same sex).....	35	35	7	22
Shared bed (opposite sex)....	2	4	1	1
Bed shared with adult.....	8	6	1	6
Room shared with adult.....	10	8	2	8
Sharing bed.....	35.7%	42.9%		32.9%
Own room.....	35.7%	31.4%		42.0%

"Living In".

Many of the families in this study were, or had been, "living in" with relatives. This is a complex social phenomenon due in part to shortage of housing accomodation, but also to economic pressure, and early marriage. It is, however, in some cases a manifestation of social pathology due to over-dependence on parents, lack of foresight in making adequate provisions, and general lack of responsibility. The results of "living in" are difficult to measure for whilst many families live in harmony others find the situation intolerable.

From the present study it was estimated that 27.5% of families 'live in' at some time. The proportion of the maladjusted and severe groups who shared accommodation in this way was significantly higher than in the control group.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe	Population Estimate.
Living in before age 5 years.....	54 (42.9%)	25 (23.8%)	8	45(51.1%)	25.9%
Living in before and after age 5 years.....	23 (18.3%)	12 (11.4%)	1	22(25%)	10.2%
Living in after 5 years only.....	1 (0.8%)	2 (1.9%)	0	0	1.6%
Living in at any time.....	55 (43.7%)	27 (25.7%)	8	45 (51.1%)	27.5%

Living in at any time Maladjusted versus Controls $X^2_2 = 7.3$ $P < 0.01$
Living in at any time Severe versus Controls - $X^2 = 12.3$ $P < 0.001$

Friction due to living in.....	13	2	0	9

Maladjusted versus Controls $X^2_2 = 10.0$ $P < 0.01$
Severe versus Controls - $X^2 = 4.8$ $P < 0.05$ (Doubtful use of Chi squared in view of small numbers).

Whilst 25.7% of the control group lived in at any time, the proportion of the maladjusted group to do so was 43.7% and that of the severe group no less than 51.1% Frank disharmony as a result of these arrangements was reported in comparatively few cases but again there was an evident excess in the maladjusted and severe groups.

Providing accommodation for relatives was less frequently encountered in the present study and no major differences emerged between the study groups.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Accommodating relatives before age 5 years.....	9	9	1	5
Accommodating relatives before and after age 5 years.....	8	7	1	4
Accommodating relatives after 5 years only.....	2	4	0	2
Accommodating relatives at any time.....	11	13	2	7

THE CHILDREN: SOME ATTRIBUTES.

Sex Distribution.

Group.	Boys.	Girls.
Maladjusted..	76	50
Control.....	59	46
Maladjusted/ Control.....	15	7
Severe.....	60	28

Maladjusted versus Control $X^2 = 0.25$ Not significant.
Maladjusted versus Control plus Maladjusted/ Control $X^2 = 0.04$ Not significant.
Severe versus Control $X^2 = 2.44$ Not significant.
Severe versus not Severe $X^2 = 3.89$ $P < 0.05$

In child guidance clinic referals there is usually an excess of boys over girls (Barbour, 1955; Holman, 1953) but there was no significant difference in sex distribution between the three main groups in this study.

The severe group, however, had a significant excess of boys if all children rated as severe are compared with all other children in the study regardless of their original group.

Birth Rank.

Place in the family is regarded by many as an important determinant in character development (Way, 1956). Lasko (1954) contrasting parent behaviour towards first and second born children found that, on average, parents are less warm emotionally and more restrictive and coercive toward first born children. Only children are often regarded as more prone to behaviour disturbances than children with siblings (Kanner, 1958). In Holman's (1953) study only children were commoner among children referred for ascertainment as maladjusted under the Education Act than in children referred to a child guidance clinic from other sources. The author attributed this to an association with 'broken homes' and a consequent tendency toward small families.

The present study showed a well marked excess of first and second born children, an excess not accounted for by the presence of only children. No significant difference was shown between the severe group and the control group despite the fact that 'broken homes' were concentrated in the former group and thus smaller families might be expected.

Birth Rank.	Maladjusted.	Control.	Maladjusted/Control.	Severe.
1st.....	63	37	9	38
2nd.....	34	28	6	26
3rd.....	12	16	5	12
4th.....	10	9	1	5
5th.....	4	3	1	3
6th.....	1	3	0	1
7th or subsequent..	2	9	0	3
Only children.....	21	14	3	15
Youngest children..	51	58	9	36
Eldest children....	42	23	6	23

Excess of first born children. Maladjusted versus Controls $X^2_2 = 4.5$ $P < 0.05$
Excess of first born children. Severe versus Controls - $X^2 = 1.0$ Not significant.
Excess of first and second born children. Maladjusted versus Controls $X^2 = 5.5$ $P < 0.02$
Excess of first and second born children. Severe versus Controls $X^2 = 2.1$ Not significant.
Excess of only children. Maladjusted versus Controls - $X^2 = 2.9$ Not significant.
Excess of youngest children. Maladjusted versus Controls $X^2 = 0.08$ Not significant.
Excess of eldest children. Maladjusted versus Controls - $X^2 = 2.6$ Not significant.

A possible explanation of these findings would be that the parents of first and second children, often young and inexperienced, through less confident handling, generate unnecessary anxiety in themselves and their children.

Height and Weight.

Since the Greek theory of humours there has been speculation on the relation between physique and temperament but it is usually agreed that Kretchmer (1921) laid the foundations for the scientific study of this relationship. The work of Sheldon (1942) and his associates has provided methods of precise observation and measurement and these methods are now in wide use, largely as research tools. Davidson, McInnes, and Parnell (1957) used them in the Oxford Child Health Survey and were

able to demonstrate a relationship between behaviour pattern and somatic components in a group of seven year old children.

In a study of children living in an institution Fried and Mayer (1948) found that children showing episodes of socio-emotional maladjustment also exhibited growth failure and that the emotional disturbance and growth retardation began and ended together. They believe that socio-emotional adjustment is critical in the growth failure and that the association can also be demonstrated in early adult life. Ferguson (1952) studying young delinquents found that delinquency and number of convictions were positively associated with small stature and marked underweight. This relationship was evident as early as the age of eight years. Similarly among adults Rees and Eysenck (1945) compared two hundred healthy soldiers with two hundred consecutive admissions to a neurosis centre and found a significantly smaller mean height among the neurotics.

Grimm (1952) observed that enuretic children tend to be underweight and below average in height. This finding has been confirmed in part in the Thousand Families Survey ("Growing up in Newcastle" 1960) in which children enuretic at any time were found to be underweight even at the age of three years, before the label of enuresis would normally be applied.

The heights and weights of the children in the present study were recorded at the ages of three years, five years and nine years. For

administrative reasons this data is not available for all the children in the study (Appendix 5). Since enuretic children, as a group, had already been shown to be under average in weight, separate mean heights and weights have been calculated for non-enuretic members of the control and maladjusted groups.

Mean Height in Inches, Mean Weight in Pounds.

Mean.	Controls.		Maladjusted.		Severe Group.
	Non Enuretic.	Full Group.	Non Enuretic.	Full Group.	
Height at 3 yrs.	36.12	36.01	36.05	36.06	35.48
Weight at 3 yrs.	31.96	31.80	31.47	31.54	30.59
Height at 5 yrs.	43.27	43.11	42.46	42.46	42.22
Weight at 5 yrs.	42.63	42.49	41.16	41.75	40.88
Height at 9 yrs.	50.13	50.07	49.83	49.83	49.45
Weight at 9 yrs.	59.55	59.33	57.82	58.18	57.70

Although the differences recorded between the above sub-divisions are not statistically significant, in paired comparisons, the order of the differences is consistent and meaningful. The children of the severely maladjusted group are strikingly smaller for each measurement than the children of any other group. In the control group the non-enuretic children are in each case heavier and taller than the control group as a whole, while in the maladjusted group the mean values for the non-enuretic members are the same or lower than those of the full maladjusted group. Finally, the mean values for the control group are higher than the corresponding values for the maladjusted group except in the case of height at three years where the difference was 0.05" in the other direction.

These figures suggest that the discrepancy in height and weight observed is associated with maladjustment rather than enuresis in this study and there is some evidence to suggest that the discrepancy is most marked.in the severely maladjusted group.

The School Report Forms.

These forms (Appendix 2) were completed in respect of 92% of the maladjusted and severely maladjusted group and 95% of the control and maladjusted/control groups. However, at least sixty different class teachers were involved in this work and it is likely that a considerable variation in scoring criteria has thus been introduced. These variations were such that the figures for 'place in class' have been discarded as impossible to evaluate. Owing to the limited capacity of the Hollerith punch cards employed in the analysis of the data of this study, other items of information recorded on the school forms have been abbreviated. Despite these limitations the information obtained seems to be of considerable interest.

Ability in School Subjects.

Class teachers were asked to rate each child as of above average, average, or below average ability in reading, arithmetic, English, art and games. Discrepancies between ability and attainment or application have been recorded as a single item for each subject. The actual total numbers in each category are shown in Appendix 5.

No significant differences emerged between the abilities as assessed by the class teachers of the maladjusted and control groups. The

severely maladjusted group however had a significantly high proportion of children in the below average category, as compared with the control group, in every school subject. No differences were evident between the three groups in respect of discrepancy between ability, and attainment or application.

	X^2 Maladjusted versus Controls.	X^2 Severe versus Controls.
Reading, ability below average....	0.4 Not significant.	4.9 $P<0.05$
Arithmetic, ability below average.	$=$ Not significant.	3.8 $P<0.05$
English, ability below average....	0.5 Not significant.	5.4 $P<0.02$
Art, ability below average.....	2.1 Not significant.	7.7 $P<0.01$
Games, ability below average.....	0.5 Not significant.	5.5 $P<0.02$

The finding that the severely maladjusted group were assessed as below average ability in games and art is rather surprising. It might be expected that children unable to cope with academic subjects would strive to shine in art or at games. It appears, however, that this group is generally poor in performance in all school subjects.

Special difficulty in a particular school subject was recorded in thirty one members of the control group, thirty eight of the maladjusted group, and thirty two of the severely maladjusted group. Compared with the control group these differences are significant only in respect of the severely maladjusted group ($X^2 = 5.8$ $P<0.02$).

School Attendance.

Excessive school absence was recorded in those instances where a child had been absent for more than 10% of possible attendances over the previous full year. This was reported in thirty one of the control group, thirty eight of the maladjusted group and thirty two of the severely maladjusted group. These differences are not statistically significant.

Punctuality.

Five children in the control group, four in the maladjusted group and seven in the severely maladjusted group were reported to be frequently late for school.

Character Traits.

Five point scales were used to rate emotional stability, temper, emotional dependence, concentration, leadership, aggressiveness, obedience, and friendliness. Rather than embark on complex statistical procedures a compromise method of analysis has been adopted. Extremes of behaviour on these scales (items A or E) have been totalled and contrasted with the total number of central items (B, C, and D). The upper (A) ratings for concentration, leadership, and friendliness are desirable traits and thus objection may be raised to equating both ends of the scales. In fact only three ratings in the control group, five in the maladjusted group, and one in the severe group related to these items. However to meet this objection in part the lower extreme (E) ratings, which are uniformly undesirable traits, have been compared with all other ratings.

	Control.	Maladjusted.	Maladjusted/ Control.	Severe.
Total extreme ratings (A & E).	37	79	14	83
Total central ratings (B, C and D).....	763	842	154	565

Extreme against central ratings. Maladjusted versus Control $X^2_2 = 10.0$ $P < 0.01$
Extreme against central ratings. Severe versus Control - $X^2 = 31.8$ $P < 0.001$

Total lower extreme ratings (E).....	30	67	12	74
Total all other ratings (A,B,C and D).....	770	854	156	574

Lower ratings against other ratings. Maladjusted versus Control $X^2 = 9.4$ $P < 0.01$
Lower ratings against other ratings. Severe versus Control $X^2 = 30.4$ $P < 0.001$.

There is a statistically significant excess of extreme ratings among the maladjusted children and this is true even when only the lower extreme (E) ratings are considered. It may therefore be concluded that undesirable character traits, as reported by class teachers, were more common among the children of the maladjusted group. The excess of undesirable traits is moreover concentrated in the severely maladjusted group.

Behaviour Disturbance in School.

The most frequently reported behaviour symptom was day-dreaming but this was not significantly more common among maladjusted children. Of the other symptoms specifically enquired for (truancy, lying, stealing, cruelty, withdrawal from fellows, soiling, and diural enuresis) all were found more frequently among the maladjusted children but the differences were not statistically significant. No symptoms were reported which had not already been revealed by the interview with mother. More surprising was the fact that no child was reported as soiling at school.

Fifty two of the children in the study were regarded by their class teachers as unduly 'nervous'. The distribution is weighted towards the maladjusted group but is statistically significant only when the control and severely maladjusted groups are compared ($X^2 = 5.6$ $P < 0.02$).

	Maladjusted.	Control.	Maladjusted/Control.	Severe.
Daydreaming.....	41	34	7	31
Other symptoms.....	40	27	7	35
"Nervous".....	21	9	3	19

"Nervous" Severe versus Controls $X^2 = 5.6$ $P < 0.02$

School Placing.

Following the 'eleven plus' examination the allocation of school places, as shown below, was not significantly different between the study groups.

	Maladjusted.	Control.	Maladjusted/ Control.	Severe.
Grammar School.....	8	8	0	3
Technical or Commercial School.....	11	9	1	5
Secondary Modern School.....	93	85	18	66
Fee paying Grammar School....	5	0	1	3
School for the Educationally Sub-normal.....	6	2	1	7
Occupation Centre.....	3	1	1	4
No grading examination.....	7	6	3	11

The Grading Examination.

This examination provides three statistics for each child, an intelligence quotient which is the mean of two Moray House Intelligence Tests, an arithmetic quotient, and an English quotient. It is beyond the scope of the present work to discuss in detail the nature of intelligence or the extent to which it is measured by these tests. The present discussion will therefore be based on the assumption that there is an association between intelligence and these tests.

Individual differences are generally considered to be due to the effect of multifactorial inheritance modified in some cases by unifactorial modes of inheritance operating particularly at the lower end of the scale (Lewis, 1957). Burt (1955) considers that at least 75% of the total variance of intelligence in the population is due to genetic influences.

That environmental factors are involved to some extent is generally accepted but there are wide differences of opinion on their relative importance.

Skodak and Skeels (1945) followed up a group of children placed for adoption before the age of six months. They found that these children corresponded with the expectations for natural children of the adoptive parents and were of superior intelligence to their natural mothers. Several other authors (Despert and Pierce, 1946; Bowlby, 1951) have reported improvement in intelligence quotient in deprived children removed to a more secure home environment.

Eysenck (1949) found confusion and contradiction in the literature regarding the association of neurosis and intelligence in adults but so far as children are concerned there is more unanimity. In a study from the Chicago Institute for Juvenile Research Kawin (1934) compared a large group of 'problem children' with a group of children regarded as well adjusted. He concluded that the problem children were, on average, of lower intelligence than those in the well adjusted group. Cattell (1936) considered it a matter of common experience 'in psychological clinics' that low attainment is frequently associated with emotional difficulties or instability and suggested that this was particularly true of chronic disability in arithmetic. In a controlled study Vernon (1937) observed that a group of neurotic children were, as a whole, somewhat below the norms on almost all tests of ability and concluded that "this confirms the existence of a moderate correlation between intelligence and emotional stability." Holman (1953) found

that a group of children ascertained as maladjusted under the Education Act had a lower mean intelligence quotient than a control group of less disturbed children referred to a child guidance clinic from other sources.

The question of whether intellectual handicaps result from or are produced by emotional maladjustment remains unanswered but the work quoted above and that summarised by Bowlby (1951) suggests that it may be possible to improve functional intelligence by treatment of emotional disorders.

A summary of the grading examination results obtained by the children in this study are shown below whilst the actual scores may be found in Appendix 5. It will be seen that in each test the control group had the highest mean score whilst the severely maladjusted group had significantly lower mean scores. The maladjusted group mean scores were in each case lower than those of the control group but the only statistically significant difference was found in the arithmetic quotient.

Intelligence Quotient.

Control group..... Mean score 99.58 Standard deviation 12.7
Maladjusted group... Mean score 96.62 Standard deviation 12.4 Standard error 1.71

Difference 2.96 Not statistically significant.

Severe group..... Mean score 93.05 Standard deviation 13.4 Standard error 1.99

Difference 6.53 = 3.3 times standard error.

Arithmetic Quotient.

Control group..... Mean score 103.11 Standard deviation 12.9
Maladjusted group... Mean score 99.35 Standard deviation 13.6 Standard error 1.8

Difference 3.76 = 2.9 times standard error.

Severe group..... Mean score 96.35 Standard deviation 13.6 Standard error 1.97

Difference 6.76 = 3.4 times standard error.

English Quotient.

Control group..... Mean score 101.05 Standard deviation 13.2
Maladjusted group..... Mean score 98.22 Standard deviation 13.15 Standard error 1.79

Difference 2.83 Not statistically significant.

Severe group..... Mean score 94.15 Standard deviation 11.8 Standard error 1.89

Difference 6.90 = 3.7 times standard error.

These figures would tend to support the hypothesis that there is an association between maladjustment, particularly with severe maladjustment, and intelligence. However this association may be linked with the finding already discussed that the maladjusted children were of smaller stature than the controls, Terman (1947) having found that children of superior intelligence were taller and heavier than their fellows.

Summary and Conclusions.

In this work an attempt has been made to study maladjustment in a child population. This population, the children of the Newcastle Thousand Families Survey, is representative only of children born in the city and county borough of Newcastle upon Tyne in the year 1947. These children were one year old when the National Health Service was introduced and until August, 1957, there were no formal child guidance facilities in the area. There were however well established paediatric and psychiatric services associated with a University Teaching Hospital.

The extent to which the children of the Survey have been influenced by eleven years of visiting has not been assessed. They did not differ from the general population of the city in respect of vaccination and immunisation rates or child welfare clinic attendances but no other

comparative details are available. It should be emphasised once again that the Survey team have endeavoured to remain observers and the families have accepted them in that role but that there will have been some modification in attitudes, on both sides, seems inevitable.

Within these limitations the survey population has the advantage that it is an unselected group so far as disturbance of behaviour is concerned. It may therefore be free of many of the disadvantages which restrict investigations of maladjustment based on clinic or juvenile court samples and using it, it becomes possible to estimate the incidence of maladjustment in the population.

The present study is based upon an arbitrarily defined maladjusted group taken from the Thousand Families Survey and contrasted with a control group which was a one in six sample of the total survey population. Those children who were originally included in both the maladjusted group and the one in six sample (control group) were separated and designated the maladjusted/control group. The "population estimates" made in this study have been based on the one in six sample, that is the control group plus the maladjusted/control group.

The mother of each child included in the study was visited in her own home and interviewed, using a questionnaire as the basis for the interview. Information obtained in this way was supplemented from existing survey records and a school report. A wide range of behaviour was considered and symptom groups defined.

It has been demonstrated that the maladjusted group manifested significantly more symptoms (an average of eleven symptoms per child, Appendix 4) than the control group. From this and other considerations it is suggested that it is reasonable to assume that the children of the maladjusted group, as a group, are clinically maladjusted.

The findings suggest that in the population 43.3% (approximately two in five) of children caused anxiety to their parents on account of nervous or emotional disturbance before the age of eleven years. It is estimated that 19.4% of the total population (approximately one in five) may be regarded as clinically maladjusted. Of the affected children only one in four of those regarded as nervous, and only one half of those considered maladjusted, received medical support or advice at any stage.

Whilst these findings relate primarily to maladjustment in, or viewed from, the home some information has been presented on the behaviour of the children in school. From the school reports it was evident that a significant association could be demonstrated between maladjustment in the home and at school. However, many children regarded as maladjusted in their homes were apparently accepted as normal by their school teachers.

The frequency of occurrence of the various symptoms is discussed in the body of the thesis. Examination of the relative frequency of these symptoms among girls and boys may offer an explanation for the preponderance of boys among child guidance clinic referals. Considering the estimates of symptom frequency in the population only two symptoms, nightmares and fears, were significantly commoner among girls than among boys. Boys were

significantly in excess with respect to truancy, wandering, stealing, destructiveness, over-adventurousness, quarrelling, extreme independence and disobedience. These antisocial activities probably have a high nuisance value which may result in earlier referral.

Factors in the background and experience of the children, which were found to be associated with maladjustment, may be divided into three main groups.

Firstly, we should consider a small group of factors concerned with the development of the child. The maladjusted group had a higher frequency of speech defects than the control group and tended to be under average in their height, weight, intelligence, and school attainment. Although this study cannot offer any confirmation it is tempting to believe that these are the results rather than the causes of maladjustment.

In the second group are factors which suggest that the pattern of maladjustment may be established early in life. These factors fall into two separate sub-groups. The first concerns the parents of the maladjusted children who, on the whole were younger than those of the control group, were comparatively recently married, frequently lived in with relatives, and were sometimes unduly reliant upon the grandparents. A high proportion of the mothers of the maladjusted children were regarded as suffering from mental ill health, and many of them had complained of psychological stress during pregnancy. Others reported that their own childhood had been unhappy. Secondly the children themselves were frequently first or second children in the family and often had a history of early problems in feeding and toilet training.

The factors referred to in the parents, may be an indication of immaturity. They suggest that the early stresses of marriage and child-bearing have been reflected in the subsequent development of their children. The early birth rank of the children and their excess of early problems would appear to support this suggestion. Many of the parents themselves come from small families and consequently had had little previous experience of caring for small children.

The thirddgroup of factors is concerned with defective inter-personal relationships. In the maladjusted group there was an excess of parents with disturbed marital relationships. Often too there was a history of friction with grandparents or other relatives which was not always the result of sharing accommodation. The most striking association however was with defective parent-child relationships. Satisfactory mother-child relationships were recorded in 73.3% of the control group but in only 38.9% of the maladjusted group. For severely maladjusted children the proportion fell to 13.6%

The place of separation experience in the aetiology of maladjustment may well be in terms of its effect upon parent-child relationships. Separation from the mother lasting longer than one month, separation from father before the age of two years, and admission to hospital, were each significantly commoner in the maladjusted group than in the control group. However, the aspect of separation experience most consistently associated with maladjustment was that of unsatisfactory care during separation. It would appear from this data that when separation occurs it is of less

importance than the circumstances in which it occurs. Separation from either parent in reasonably favourable circumstances was not significantly associated with maladjustment.

Having outlined the main conclusions of the study which suggest that maladjustment is more common than is generally believed it is now possible to consider whether or not maladjustment should be regarded as a serious problem. Cummings (1946) and Valentine (1956) believe that most behaviour difficulties tend to resolve spontaneously. Others including Winnicott (1953) and Kanner (1957) believe that although a symptom may tend to disappear its appearance was an indication of underlying disturbance likely to be replaced by other symptoms. While detailed evidence is not available in the present study on the natural history of individual symptoms it has been shown that of fity one children considered to be maladjusted before the age of five years only ten (19.6%) were regarded as within normal limits for behaviour at the age of eleven years. The association between management problems in infancy, which MacKeith (1955) would regard as emotional problems, and subsequent maladjustment, has also been demonstrated.

There is little evidence available on the subsequent adult development of maladjusted children. O'Neal and Robins (1958) followed up a group of patients referred to a child guidance clinic thirty years previously and compared them with a matched group of normal controls. They found a high rate of adult psychiatric illness among the child guidance group with many cases of 'sociopathic personality' (Psychopathy), psychotic reaction, and alchoholism, though the two groups differed little in their rate of neurotic reactions.

On available evidence the consequences in adult life of maladjustment in childhood are difficult to predict. There is however a prima facie case for regarding maladjustment as the forerunner of disturbance in adult life and the distress which may be caused to the child and his family is in itself a sufficient reason for attempting to prevent and treat maladjustment.

Any programme concerned with the improvement of mental health in childhood must consider three aspects of the problem, prevention, ascertainment, and treatment. It is relevant, at this point to consider what steps could be taken to implement such a programme. Despite the basic deficiencies in our knowledge in this field and the urgent need for further research these problems must be tackled within the framework of present experience and with available personnel.

It is evident from the present study that in many instances there are environmental factors operating early in life which may have a detrimental influence on the child's emotional development. Indeed the Underwood Report (Min. of Ed., 1955) recommends that prevention should begin in ante natal clinics. At these clinics facilities should be provided not only for education in child rearing practices but for the advice and treatment of mentally disturbed mothers. This object could be achieved through group discussions led by an obstetrician, paediatrician, or psychiatrist who had facilities for referal of problems beyond the scope of the group. Similar facilities could be provided later through the child welfare centres which should be primarily educational and preventitive in outlook.

The role of the health visitor is increasing in the field of health education. She has unique opportunities for early entry into the home

where she is usually an accepted visitor and frequently asked by parents for advice on general questions of child management. Unfortunately her training and experience does not always equip her to recognise early signs of maladjustment. This deficiency however can be remedied. Increasing emphasis should be placed on mental hygiene in health visitor training and In Service training in the emotional aspects of child development could be provided. In many areas health visitors may work in too great isolation from general practitioners and the hospital services a state of affairs which can only be improved by better understanding by each of the others problems.

At present, School Nurses, though they often have health visitor training, frequently function independently of the health visitor. In these circumstances, they are often unaware of the home background of the children in their care, and frequently have no contact with the parents. If the duties of the health visitor and school nurse could more often be combined, better continuity of care might be achieved. School medical officers would certainly find their work more fruitful if they could be appraised of the background of the children they examine.

The General Practitioner has a crucial role to play in management and education but is not always adequately equipped by his training and experience. (In some areas, also, there is an unfortunate trend whereby each member of a family has a different doctor. Such a break from the traditional concept of the family doctor must impair the doctor's understanding of the patient's background and problems). The recommendations for the extension of undergraduate education in psychiatry, made by the Royal College of Physicians, (1943), have still not been implemented.

Even in those schools providing teaching in psychiatry, the emotional problems of childhood receive less attention than they merit. In areas where facilities are available for the treatment of maladjusted children, the responsible clinics should be encouraged to shoulder the additional burden of educating practitioners, preferably through children they have referred themselves.

The medical officers of the school health service, play an important, but potentially greater,part in the prevention and recognition of maladjustment. Often they are hampered by routine medical examinations in which they are required to examine large numbers of children, often unaccompanied by their parents, and usually without any knowledge of the children's home background. Local authorities may now make provision for reducing the number of routine inspections in favour of a system of regular consultation sessions within the school. Such a system is welcome and should provide better opportunities for discussion and consultation between doctors, teachers and parents.

Under the Education Acts, educational psychologists now have many duties and they can only contribute to education and ascertainment in the field of mental hygiene if existing services are expanded. In many areas, there are no facilities for the proper investigation of specific educational defects. Children may be referred for ascertainment as educationally subnormal, but lesser degrees of retardation are managed within the school. Many children who are virtually not educable within the ordinary secondary modern school, reach school leaving age without any attempt being made to determine the cause of the disability.

Speech therapy units, often within the school health service, are likely to be called upon to treat many maladjusted children. Whilst speech therapists are usually aware of this aspect of their work, often they have no facilities for joint consultation with a child psychiatrist, in the management of problems of maladjustment.

School teachers have more opportunity than anyone, other than the parents, to get to know the children in their classes. A sympathetic teacher can to some extent, mould and develop the attitudes and outlook of the children under her care, to foster healthy mental and emotional development. She is in a position to recognise the early signs of emotional disturbance in one of her children, and it is obviously vitally important that the training of teachers should include comprehensive instruction about the emotional needs and development of children, and the early signs of maladjustment. There should also be freely available, and informal, opportunity for school teachers to seek expert advice on both general and specific problems in this field.

Despite every effort by the groups already discussed, the most important people in the sphere of prevention and ascertainment of maladjustment, are, of course, the parents. The atmosphere of the home and his relationships with his parents, are the factors most likely to influence the child's emotional adjustment. It is probable that most parents, by their own intuitive methods, can find a satisfactory system of child rearing, but all must experience doubts and the need for advice at some times. Many will be able to seek help from the sources already

discussed, but others must be reached by more direct propaganda methods. Popular, inexpensive handbooks on child development, (Spock, 1946, de Kok, 1959) are widely read; radio talks and television features could be used to reach a wide public. The National Association for Mental Health has produced a series of pamphlets for the guidance of parents, and these or similar leaflets could be made more readily available. Ideally any parent should be able to obtain expert advice, preferably from one of the sources already mentioned. However, if this is not possible it may be desirable for the paediatrician or child psychiatrist to accept referals from non-medical sources at times.

The treatment of maladjustment is usually regarded as the province of the psychiatrist but at present, the psychiatric services cannot hope to meet their responsibilities fully. Expansion of the child psychiatric services is continuing but the needs as estimated by Blacker (1948), and the Underwood Committee (Ministry of Education, 1955) have not been met, though these needs were based on a smaller incidence of maladjustment than the present study would suggest. Even if psychiatric services could be provided on a massive scale, it is by no means certain that all psychogenic illness would be referred to child psychiatrists. The early stages of emotional disorder are often seen in the paediatric clinic. Problems of infant feeding and habit training are surely the proper province of the paediatrician. Many symptoms such as encopresis and motor tics are seen by the psychiatrist only when they are well established, whereas a paediatrician may have the opportunity to observe the natural history of

these conditions. The paediatrician's part in the treatment of maladjustment will depend upon his own training and interest; the material will be there if he can recognise it.

Illustrative of the different attitudes taken by a number of paediatricians to the children referred to them, were the results of an informative study carried out by Dr. Mildred Creak at the Great Ormond Street Hospital for Sick Children. The 15 registrars with out-patient responsibilities, all experienced in their speciality, were asked to grade all out-patients into three groups. In the first group were children in whom emotional factors played no part in their complaint, a second group of children with well defined physical factors but in whom emotional factors helped to maintain symptoms and a third group in which the complaint was mainly or entirely due to emotional disorder.

The results showed a wide scatter. At one end of the scale a paediatrician regarded 86% of his cases as purely physical, whilst at the opposite extreme, another registrar would label only 28% as purely physical. One registrar regarded 40% of all cases seen, as purely emotional in origin. This study was carried out in our foremost postgraduate teaching hospital with experienced registrars all seeing similar material.

It is evident that whilst experience in child psychiatry is required at all levels of training in paediatrics, not all paediatricians will have the interest in undertaking this kind of work. An influential group of paediatricians headed by Winnicott (1958), believe that those paediatricians who wish to undertake treatment of emotional disorders, should themselves undergo a personal psychoanalysis. Whilst this represents a selected

viewpoint, there is certainly good reason to suggest that such paediatricians should have an opportunity for comprehensive training in child psychiatry, just as others have special experience and training in cardiology or other sub-specialities.

Paediatricians who do undertake the recognition and treatment of emotional disorder may be encouraged by the work of Apley (1959) who has demonstrated the value of close liaison between the paediatrician and the psychiatric clinic. In the past two years he has taken his work a step further and by direct co-operation between the paediatrician and the psychiatric social worker, is treating emotionally disturbed children in a paediatric clinic with reference to a psychiatrist only in exceptional circumstances. This technique has added value on the all too frequent occasions when the parents, or doctor, are biased against referal of the child to a psychiatrist.

Finally we come to the child guidance team of child psychiatrist, psychiatric social worker and psychologist. The training of the last two professional groups is now fairly clearly established. So far as the psychiatrist is concerned this is unfortunately not so. It is still possible for a psychiatrist to be appointed to a children's unit with little experience or training in the speciality, nor is it clearly established what kind of training is desirable.

At present the child psychiatrist usually acquires his basic training in adult psychiatry. This has evident advantages not the least of which is the understanding this may give him of the problems of the parents. However his training is often deficient in experience of both healthy

children and well adjusted sick children. Such experience would surely broaden his outlook as a psychiatrist and improve his understanding of the problems of the paediatrician with whom he must work. There is much to be said for encouraging the child psychiatrist to take his place as a member of the staff of the children's hospital or out-patient department, sharing the responsibility for the care of children in and out of hospital.

There can be little doubt that maladjustment in childhood is a major problem. All concerned with the care of children and their parents have a part to play in the prevention, ascertainment and management of maladjustment. This is a community problem to which no group has exclusive rights and all must work in closest co-operation to resolve it.

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A P P E N D I X 1

BEHAVIOUR PRO-FORMA

APPENDIX I (Complete)

MOTHER

Age at birth of R.S. _____ Age at marriage _____

Previous employment _____ Father's occupation _____

Education: Elem. Gram. Pub.Sch.or Private Univ.

FATHER

Age at marriage _____ Trade or profession _____

No.of jobs since 1947 _____ Father's occupation _____

Education: Elem. Gram. Pub.Sch.or Private Univ.

Has he a favorite brother or sister. _____

Has he a brother or sister he doesn't get on with _____

SIBS.

How does R.S. get on with

	Age	Occup.	v.well	well	indiff.	dislikes	hates
1.							
2.							
3.							
4.							
5.							
6.							
7.							

RELATIVES

Other relatives in household (at any time) _____

Maternal G/parents

Frequency of visits/week To _____ From _____

Relations with Good Indiff. Bad

Interference from Much Some None

Other difficulties

Paternal G/parents

Frequency of visits/week To _____ From _____

Relations with Good Indiff. Bad

Interference from Much Some None

Other difficulties

FAMILY GROUP

<u>Never established</u>

Illegitimacy

Parents always lived apart

Tenuous relationship

<u>Broken home</u>

Death

Desertion

Divorce

Separation

<u>Not functioning effectively</u>

Adverse economic conditions

Chronic illness or disability

Mental illness or instability

Father working away from home

Mother working full time

Imprisonment

HOME LIFE

Was your home life as a child a happy and secure one? If not, what was the trouble?

Has this had any effect on your own married life?

Was your husband's home life as a child a secure and happy one? If not, what was the trouble?

Has this had any effect on your married life?

Would you describe your home life now as happy, average,

or unhappy?

MARITAL RELATIONSHIP Assessment based on interview plus records.

V.good Good Average Unsatisfactory Bad

PSYCHIATRIC DISORDER

Mother	Father
I.P. Psychiatric	I.P. Psychiatric
O.P. Psychiatric	O.P. Psychiatric
Other hosp. diag.	Other hosp. diag.
G.P. diag.	G.P. diag.
Other evidence	Other evidence
"Nerves" (own statement)	"Nerves" (Own statement)

Disorder in other members of family:

Other evidence of family instability:

(a) Crime
(b) Excessive drinking
(c) Cruelty or violence
(d) Venereal disease
(e) Gambling
(f) Epilepsy
(g) Chronic unemployment
(h) Social dependence
(i) Chronic illness
(j) Chronic debt
(k) Promiscuity

Physical standards

(a) Personal cleanliness
(b) Domestic cleanliness
(c) Defective clothing
(d) Defective diet
(e) Defective supervision

HOUSING Type of House Duration of occupation

No. of rooms No. of removals (since 1947)

No. of occupants Result of change:
improved no change worse

SLEEPING ARRANGEMENTS

Satisfactory Indifferent Bad Unavoidable/otherwise

PREGNANCY Obstetric history (incl. misc.)

Health during pregnancy Existing records Mother's statement

Toxaemia

Bleeding

Other physical illness

Worries, stress etc.

Labour

Infant Mature/prem Health in neonatal period:
Good Indifferent Poor
(also specify below)

INFANT FEEDING

Breast (duration) _____ Bottle (duration) _____

Weaning began _____ Abrupt/gradual _____

Completely stopped breast/bottles _____

Feeding difficulties _____

TOILET TRAINING

When began _____ Regular routine established ____

Out of nappies _____ Bowel control _____

Dry: By day _____ By night _____

Difficulties _____

MILESTONES Standing First steps First words

Sentences Playing alone outside Others

FAMILY SIZE What do you think is an ideal size for a family?

How many would you have if you could start again?

Would you like more children?

Birth control?

Were any past pregnancies unplanned?

LOSS OF MOTHER Ages at which loss occurred.

Duration: 3/12 - 2 years 2 years-5 years Permanent

LOSS OF FATHER Ages at which loss occurred

Duration: 3/12 - 2 years 2 years-5 years Permanent

SEPARATIONS NOT AMOUNTING TO LOSS

1st year _____

1-3 years _____

Subsequent _____

NURSERY ADMISSIONS (Day or residential)

DAY FOSTERING

HOSPITAL ADMISSIONS Visiting whilst in hospital

MOTHER WORKING FULL TIME PART TIME

MOTHER (Observers impressions)

FATHER

MOTHER'S RELIGION Churchgoing regular occas. spec.events never

FATHER'S RELIGION " " " " "

PARENTAL REJECTION Mother Father

Evidence accepted

(a) undue protectiveness or anxiety for the child's health or safety

(b) excessive protestations of devotion

(c) behaviour towards the child less intelligent than that of the parent in other directions

(d) unkindness or frank cruelty

(e) other (specified)

PARENTAL ASPIRATIONS

Are you content in your present house and area?

Is father satisfied with his job?

Can you manage on your present income?

What is your total income?

What kind of education would you like R.S. to have?

What sort of job would you like to see him in?

Do you think R.S. is or has been emotionally disturbed, troubled with his nerves, or a worry so far as his behaviour is concerned?

If so, have you sought advice?

from whom?

was it helpful?

Would any other source of advice have been welcome?

Place in class/number in class/stream

Teachers assessment

Grading exam.

Psychologists exam.

Number of schools attended

School absence

Physical handicaps

Handedness

Physical illness (incl. asthma, eczema, fits, skin disorders, abdominal pain)

Delinquency Police visits Juvenile Courts Probation

Informant Co-operative Indifferent Hostile

Other persons or factors affecting interview

12345 NR Does he have dreams _____

12345 NR SW Is he restless at night _____

Is he difficult to wake During night In mornin

Hours of sleep at night _____

12345 NR Does he wet his bed _____

12345 NR Does he wet himself by day _____

12345 NR Does he soil himself _____

12345 NR Is his appetite good _____

Does it vary _____

12345 NR Has he any special food dislikes __

12345 NR Does he have any mannerisms, habits or tics such as blinking, chewing his clothes, etc. _____

12345 NR Does he bite his nails _____

12345 NR Does he suck his thumb _____

12345 NR Do you think he is restless or overactive _____

12345 NR Does he ever wander/run away/ from home _____

12345 NR Does he ever run away from school

12345 NR Does he tell many lies _____

12345 NR Does he often take things belonging to other people _____

12345 NR How careful is he with toys and clothes _____

12345 NR Do you have much difficulty in getting him to share his things with others

12345 NR Does he quarrel much _____

With whom _____

12345 NR Is he overdependent _____

12345 NR Does he try to do things for himself

12345 NR Is he shy _____

12345 NR Is he timid or adventurous _____

12345 NR Is he afraid of anything _____

If so, what _____

12345 NR What sort of temper has he got {Degree / Frequ}

12345 NR Is it easy to irritate or upset him

12345 NR How does he respond to orders or suggestions

12345 NR Does he appear jealous of anyone

Of whom _____

12345 NR Does he fuss to receive attention

12345 NR Is he sensitive or easily hurt

12345 NR By and large is he sad and serious or cheerful and carefree

12345 NR Does his mood vary very much

12345 NR Is he reserved _____

12345 NR Does he always want to win

12345 NR Is he shy about undressing

12345 NR Does he ever handle/play with himself

Is he secretive/ashamed about this

12345 NR Does he show any interest in sex

12345 NR Have you or father discussed "the facts of life" with him

FRIENDS

How many friends would you say he has

Many Few 1-2 None (Gang) Op.sex

How do his friends compare in age

Much older older same age younger much younger

Does he often change his friends

Never occasionally often

Does he bring his friends home

Often occasionally never

Do you like him to bring friends home

Does he have to be boss

Yes joins in follows

Attitude to visitors

Sociable Indifferent Unsociable "Showing off"

RECREATION

Member of Youth Orgns. No Type Attendance

Leader Joins in Follows

Cinema Never /1 p.w. 1 p.w. 2 p.w. 3-3 p.w.

Other evenings out p.w. With family Without family

Televiewing Hours p.w. Own set Yes/no

Pocket money Average p.w. Any other income?

Hobbies

HOME

How does he get on with father v.well well fair poor badly

How does he get on with mother v.well well fair poor badly

Does he help in the house Frequently Infrequently Never

Does family get out much together gt.deal, quite often, now & then seldom, almost never

Does father regard bringing up the child as mother's responsibility joint-venture his responsibility

Does he take the child out Frequently Infrequently Never

Who is responsible for discipline

What punishments are used

Who administers them

Do they give rise to any disagreement

A P P E N D I X 2

SCHOOL REPORT

APPENDIX 2 (Complete)

PRIVATE AND CONFIDENTIAL — THOUSAND FAMILY SURVEY

N.B. Where brackets are provided please answer questions by placing a cross in the appropriate bracket.

NAME OF PUPIL: _____ SCHOOL: _____

Is this form to be completed by the pupil's present class teacher? Yes ( ) No ( )

If not, by whom? _____

How long have you known this pupil? _____ years

SCHOOL PROGRESS

Position in class (expressed as place in class over number in class) this is based on
- School examination / ( )
- School examination & teacher's assessment ( )
- Teacher's assessment ( )

How is this pupil's age group divided in your school and in which division is he placed? e.g. streamed or parallel classes _____

Grading exam. placing
- Secondary modern ( )
- Technical or commercial ( )
- Grammar school ( )
- Other (please specify) _____

Is this result in accordance with your expectation for the pupil?
Yes ( ) No ( )
If not, state reason

School Work — In this block please rate pupil as above average (a), average (b), or below average (c) in each subject, in respect of ability, attainment, and attitude e.g. this pupil might be, in arithmetic, of above average ability (a), but average attainment, (b), and lacking in interest and application (c). Indicate your rating by a cross in the appropriate square.

SUBJECT	ABILITY			ATTAINMENT			INTEREST & APPLICATION		
	A	B	C	A	B	C	A	B	C
Reading									
Arithmetic									
English									
Drawing or Art									
Games									

Does this pupil show any special difficulty or conversely special interest or ability in <u>any</u> school subject? Yes ( ) No ( ) If yes, please state subject(s) and comment.

<u>School attendance</u> From Sept. 1st 1957 to date. No. of attendances/No. of possible attendances

In case of frequent absence from school please state cause if known ____

<u>Punctuality</u> Persistently late ( ) Frequently late ( ) Occasionally or never late ( ) Does child show <u>excessive</u> panic or anxiety if late Yes ( ) No ( )

<u>Personal cleanliness</u> Excessively clean and tidy ( ) Clean and tidy ( ) Dirty and untidy ( )

<u>Clothing</u> Always well dressed ( ) Usually adequately clad ( ) Inadequately and poorly clad ( )

<u>BEHAVIOUR</u>

1. <u>Trait ratings</u>. In the following ratings consider each trait separately and in relation to other children of the same age. We assume that most children will have a central rating (C) with correspondingly fewer children towards the A or E ends of the scale. Each child should be given a single rating in respect of each trait. Indicate your rating by making a cross in the brackets provided against the group of characteristics most accurately describing this child's behaviour.

Emotional stability

A ( )	B ( )	C ( )	D ( )	E ( )
Excitable Highly strung. Emotional outbursts.Unstable	Inclined to emotional outbursts	Normally emotional in control and expression	Shows weak power of emotional response	Emotionally apathetic

Temper

A ( )	B ( )	C ( )	D ( )	E ( )
Frequent and violent temper outbursts.Often without apparent reasn.	Frequent outbursts of temper with minimal provocation.	Normal temper can be provoked	Requires more provocation thm average.Rarely loses temper	Never loses temper in any situation.Unusually placid.

Emotional dependence

A ( )	B ( )	C ( )	D ( )	E ( )
Aggressively independent.Look after himself and resents any help.	Very independent.Occasionally accepts help but rarely asks for it.	Fairly independent but asks for help when necessary	Can manage but needs frequent Encouragement	Very dependent of presence and encouragement of mother or other trusted person.Constant demand for attention

Concentration.

A ( )	B ( )	C ( )	D ( )	E ( )
Excellent power of sustained concentration.Not influenced by most distractions.	Absorbed in what he does.Shows strong power of attention.	Concentrates normally except when distractions present.	Easily distracted weak powers of attention.	Rarely attend for long. Short term attention. Never really absorbed.

Leadership.

A ( )	B (,)	C ( )	D ( )	E ( )
Always assumes leadership of group.Never any question of sharing responsibility.	Usually leader but can tolerate suggestions from others.	Joins in activities. Shares leadership but does not dominate group.	Joins in easily but rately assertive.	Easily led. Never makes suggestions. Fringe member of any group

Aggressiveness

A ( )	B ( )	C ( )	D ( )	E ( )
Constantly quarrelsome. Always bullying or fighting with other children.	Inclined to be quarrelsome.Often starts fights.	Prepared to defend himself.Occasionally starts fights.	Defends himself under provocation but avoids fighting if poss Rarely st fights	Never fights even in self defence. Submits to domination by other chil

Response to orders or suggestions				
A ( ) Frankly disobedient or negativistic.	B ( ) Resistant to suggestion. Needs pressure to secure obedience.	C ( ) Obedient of authority but has ideas of his own. Sometimes needs persuasion.	D ( ) Rarely questions orders. No. persuasion required to achieve obedience	E ( ) Exceptionally obedient and biddable Passive.
Friendliness				
A ( ) Exceptionally popular. Friendship widely sought among fellows.	B ( ) Has many friends joins other groups easily.	C ( ) Normally friendly. Has a few special friends and plays with other groups.	D ( ) One or two friends, only. Tends not to play with other groups.	E ( ) Aloof from others. Avoids groups No particular associates.

2. Has this pupil shown any evidence of the following (indicate by a cross in the appropriate column).

	Frequent	Occasional	Never
Truancy			
Lying			
Stealing			
Cruelty			
Day Dreaming			
Withdrawal from fellows			
Soiling			
Daytime wetting			

Additional comment on these features:-

3. Has this pupil exhibited any habits or behaviour which you consider abnormal or which might be a manifestation of nervousness or emotional disturbance (please include any minor items such as nail biting or restlessness).

ADDITIONAL COMMENTS
(if any)

By Class Teacher

By Headmaster.

A P P E N D I X 3

A FIRST APPOINTMENT LETTER

B SECOND APPOINTMENT LETTER

C HOLLERITH CODING LIST

APPENDIX 3A

From Dr. S. Brandon

Date.

Dear Mrs.

I am at present trying to see the mothers of all 'Red Spot' children in order to ask them to help with a special problem with which we are dealing. We are anxious to ask a number of questions about the development of 'Red Spot' children which might help us to understand a group of ill children in our care.

This would involve me calling on you at home, preferably when the children are not there, and would take about an hour of your time. I would be most grateful if you could see me and will call on you at home at ..... If this is not convenient would you please suggest a more convenient time and let me know using the enclosed card.

Yours sincerely,

APPENDIX 3B

From Dr. S. Brandon

Date.

Dear Mrs.

As you probably know I have been trying to see the mothers of all 'Red Spot' children to ask their help in a special survey. The survey is concerned with the behaviour of normal children and simply mothers answering some questions about ..... early development and habits. It should take about an hour and I can arrange to call at any time convenient to you. If you cannot spare an hour at present perhaps I could see you and discuss a later appointment.

Will you please use the enclosed post card to let me know when I may call.

Yours sincerely,

APPENDIX 3C

Col. 1,2,3,4 Index Number

Col.5
- /Y Affected
- /X Control
- /0 Affected/Control
- /1 Male
- /2 Female
- /3 Grammar School } Grading exam.
- /4 Tech.or comm. } Grading exam.
- /5 Sec.modern } Grading exam.
- /6 No record } Grading exam.
- /7 Private School
- /8 E.S.N. (ascertained)
- /9 Occupation centre

Col.6
- /Y 20 years
- /X 20-25
- /0 26-30 } Mother's age at birth of Red Spot
- /1 31-35 } Mother's age at birth of Red Spot
- /2 36-40 } Mother's age at birth of Red Spot
- /3 40 } Mother's age at birth of Red Spot
- /4 20
- /5 20-25
- /6 26-30 } Father's age at birth of Red Spot
- /7 31-35 } Father's age at birth of Red Spot
- /8 36-40 } Father's age at birth of Red Spot
- /9 40 } Father's age at birth of Red Spot

Col.7
- /Y Professional
- /X Employer of 10 or more
- /0 Salaried
- /1 Black coated
- /2 skilled manual
- /3 Semi-skilled
- /4 Unskilled
- /5 Agricultural
- /6 Self-employed or farmer
- /7 N.R.
- /8 Job history stable
- /9 Job history unstable.

Col.8
- /Y Professional } Maternal grand-father
- /X Employer of 10 or more } Maternal grand-father
- /0 Salaried } Maternal grand-father
- /1 Black coated } Maternal grand-father
- /2 Skilled manual } Maternal grand-father
- /3 Semi-skilled } Maternal grand-father
- /4 Unskilled } Maternal grand-father
- /5 Agricultural } Maternal grand-father
- /6 Self-employed or farmer } Maternal grand-father
- /7 NR.
- /8 Family improved in social status
- /9 Family down in social status

Col.9
- /Y Professional } Pat. grd' fathr
- /X Employer of 10 or more } Pat. grd' fathr
- /0 Salaried } Pat. grd' fathr
- /1 Black coated } Pat. grd' fathr
- /2 Skilled manual } Pat. grd' fathr
- /3 Semi-skilled } Pat. grd' fathr
- /4 Unskilled } Pat. grd' fathr
- /5 Agricultural } Pat. grd' fathr
- /6 Self-employed or farmer } Pat. grd' fathr
- /7 N.R. } Pat. grd' fathr
- /8 Famy.improved in social statu
- /9 Famy.down in social status

Col.D
- /Y Social trend up in last 10 yr
- /X Social trend down in " " "
- /0 Married 1 yr.at birth of RS.
- /1 " 1-3 " " " "
- /2 " 4 " " " "
- /3 Cohabiting
- /4 Unmarried
- /5 Living in } Adcom.relatives
- /6 Adcom.relatives } Friction resulting
- /7 Friction resulting } 5 years
- /8 5 years } 5 years
- /9 5 years } 5 years

Col.11/Y Reg.contact with mat.grd'pts.
/X 5 visited at least once pr wk.
/O 5 " " " " " "
/1 Reg.contact with pat.grd'pts.
/2 5 visited at least once pr wk.
/3 5 " " " " " "
/4 Mat.grdmother integral part of famy.grp.i.e.considerable reliance or domestic help
/5 Pat.grd.mother " " " " "
/6 Excessive dependence or domination by grandparents.
/7 R.S. largely cared for by g/mother or other person - mother still alive.
/8 ditto - since mother's dth.
/9

Col.12/Y 1st
/X 2nd
/O 3rd
/1 4th
/2 5th
/3 6th
/4 7th
/5 1
/6 2
/7 3
/8 4
/9 5
} Birth rank
} subs.infants

Col.13/Y Elementary
/X Tech./Comm.
/O Grammar
/1 Public sch/pte.
/2 University
/3 Happy chldhood
/4 Qualified "
/5 Unhappy "
/6 2
/7 2-5 loss of
/8 6-10 parent
/9 11-20
} Mother

Col.14 /Y Elementary
/X Tech./Comm.
/O Grammar
/1 Public sch/pte.
/2 University
/3 Happy chldhood
/4 Qualified "
/5 Unhappy "
/6 2
/7 2-5 loss of
/8 6-10 parent
/9 11-20
} Father

Col.15 /Y Happy
/X Average
/O Unhappy
} Home

/1 very good
/2 good
/3 average
/4 unsatis.
/5 bad
} assessment

/6 never established
/7 tenuous
/8 broken
/9 not functioning effectively
} Famy. grp.

Col.16 /Y Sib.with higher education
/X Behaviour problem in sib.
/O Delinquency in sib.
/1 ESN or MD in sib.
/2 O.C. died
/3 subs. infant died
/4 F.H. epilepsy
/5 " psychiatric disorder
} M

/6 Epilepsy in M

/7 F.H. epilepsy
/8 " Psych.dis.
/9 Epilepsy in F.
} E.

Col.17/Y I.P. psychiat.
/X O.P. psychiat.
/O Other hosp. diag.
/1 G.P. diag.
/2 Other evidence
/3 'nerves'
/4 I.P. "
/5 O.P.
/6 Hosp.
/7 G.P.
/8 Other
/9 'Nerves'

M.

F

Col.18/Y Crime
/X Excess drink
/O Cruelty or violence
/1 V.D.
/2 Gambling
/3 Chronic unemployment
/4 Social dependence
/5 Chronic illness
/6 Chronic debt
/7 Primiscuity
/8 Epilepsy or fits in RS
/ " " " " sibs.

in immediate family

Col.19/Y Good
/Y Average
/O Below average

Physical standards in home

/1 Feeding difficulties
/2 Breast fed
/3 Weaned before 1 fr. i.e. from bottle or breast
/4 Early difficulty with toilet training
/5 Remote " " "
/6 Toilet training started 3/12
/7 " " 3/12-1 yr.
/8 " " after 1 yr.
/9 Items 18/Y-7: other family history.

Col.20/Y Detached
/X Semi
/O Council
/1 Terrace
/2 Hungalow
/3 Pre-fab
/4 Flat in block
/5 Flat in house
/6 Rooms
/7 Council owned
/8 Changed house improvement
/9 " " worse

Col.21/Y 1
/X 2
/O 3
/1 4
/2 5
/3 6
/4 7
/5 8
/6 9
/7 10

Occupants

/8 Sleeping arrangements, unsatisfactory
/9 Condition avoidable.

Col.22/Y 1
/X 2
/O 3
/1 4
/2 5
/3 6
/4 7

No. of Rooms

/5 2 Yrs.
/6 2-5 Occup.
/7 5
/8 1
/9 2 Removals

Col.23/Y Normal)Labour
/X Norm.with complaint) and
/0 Abnormal)Delivery
/1 Toxaemia)
/2 Physical illness)During
/3 Bleeding)pregnancy
/4 Stress)
/5 Mature
/6 Premature
/7 Good)
/8 Indfferent)Neonatal condition.
/9 Poor)

Col.24/Y More)Ideal size as comp.to actual
/X Less)(Punch neither for "same")
/0 More)than actual if starting again
/1 Less)(punch neither for "same")
/2 Yes Would like more.
/3 No) Birth
/4 Yes) Control
/5 No) R.S.
/6 Yes) planned
/7 No) Others
/8 Yes) planned
/9 N.R. (whole section)

Col.25/Y 6/12)Sep.from mother
/X 6/12-1 yr.) (exc.hosp.adm)
/0 2nd yr.)
/1 3rd ") age at 1st sepn.
/2 4th ")
/3 5th ")
/4 subs")
/5 1/12)
/6 1-3 mths)Duration of sepn.
/7 3/12)
/8 Satisfactory)Care during
/9 Otherwise)separation

Col.26/Y 6/12)Sep.from Father
/X 6/12-1 yr.) (exc.hosp.adm.)
/0 2nd yr.)
/1 3rd ") age at 1st sepn.
/2 4th ")
/3 5th ")
/4 Subs.)
/5 1/12)
/6 1-3 mths) Duration of sepn.
/7 3/12)
/8 Satisfactory) Care during
/9 Otherwise) separation

Col.27/Y Hosp. admission 1
/X " " 2
/0 " " 3+
/1 duration " 1/12
/2 " 1/12 - 3/12
/3 " 3/12
/4 Age 1st adm. /12
/5 " " " 6/12-2 yrs.
/6 " " " 2 yrs.-5 yrs.
/7 " " " 5+ years.
/8 Squint
/9 Other visual defect.

Col.28/Y 1/12
/X 1/12-6/12
/0 6/12
/1 Day
/2 Residential
/3 Day fostering
/4 F.T. work M.
/5 P.T. work M.
/6 1 yr.)
/7 1-3 yrs)Age when M.comm.
/8 3-5 yrs) work
/9 5+ yrs)

Col.29/Y Satis. } R.S.reltnship
/X Unsatis } with
/0 Variable } mother
/1 Not known }
/2 Satis. }
/3 Unsatis } ditto
/4 Variable } with father
/5 Not known }
/6 C. of E. }
/7 R.C. }
/8 Convert } Mother
/9 Other }

Col.30/Y C. of E. }
/X R.C. }
/0 Convert } Father
/1 Other }
/2 C. of E. }
/3 R.C. } R.S.
/4 Convert }
/5 Other }
/6 Reg. }
/7 Occ. } Mother
/8 Spec.event }
/9 Never }

Col.31/Y Reg. }
/X Occ. } Father
/0 Spec.events }
/1 Never }
/2 Regular S.S. } R.S.
/3 Intermittent SS }
/4 Religious differences in family
/5 No idea }
/6 Whatever he wants }
/7 Professional } Job
/8 Trade } aim
/9 Non-skilled }

Col.32/Y Content house and area Yes
/X " " " No
/0 Satis. with job Yes
/1 " " " No
/2 Manage income Yes
/3 " " qualified
/4 " " No
/5 Husband's wage N.K.
/6 Private, Public } Parents
Boarding School } aim
/7 Grammar }
/8 Tech./Comm }
/9 Sec.mod. }

Col.33/Y 10/- } Income
/X 10-19 } per
/0 20-29 } head
/1 30-39 }
/2 40-49 }
/3 50-59 }
/4 60-69 }
/5 70-79 }
/6 80-89 }
/7 90-99 }
/8 £5 }
/9 N.R. }

Col.34/Y Speech defect before 5 yrs
/X " " after 5 yrs
/0 Stammer at any time
/1 Emotional disturbance Yes
/2 " " qualified
/3 " " No
/4 Help needed
/5 Help sought
/6 Further help desired
/7 Wheezing
/8 Eczema
/9 Headache

Col.35/Y Abdominal pain
/X L.H.
/0 R.H.
/1 Police visits } either
/2 Probation } or
/3 Informant co-operative
/4 " otherwise
/5 Other adults present
/6 Children present
/7 2 visits
/8 3 visits
/9 Special difficulty in obtaining interview.

Col.36/Y A.Q. 75-84
/X 85-89
/0 90-94
/1 95-99
/2 100-104
/3 105-109
/4 110-114
/5 115-119
/6 120-124
/7 125-129
/8 130-134
/9 135

Col.37/Y A.Q. 75-84
/X 85-89
/0 90-94
/1 95-99
/2 100-104
/3 105-109
/4 110-114
/5 115-119
/6 120-124
/7 125-129
/8 130-134
/9 135

Col.38/Y E.Q. 75-84
/X 85-89
/0 90-94
/1 95-99
/2 100-104
/3 105-109
/4 110-114
/5 115-119
/6 120-124
/7 125-129
/8 130-134
/9 135

Col.39/Y A) Reading
/X B)
/0 C)
/1 Discrepancy
/2 A) Arithmetic
/3 B)
/4 C)
/5 Discrepancy
/6 A) English
/7 B)
/8 C)
/9 Discrepancy

Col.40/Y A) Art
/X B)
/0 C)
/1 Discrepancy
/2 A) Games
/3 B)
/4 C)
/5 Discrepancy
/6 Grading exam.discrep.
/7 Grading exam.in County
/8 Spec.schl.difficulty
/9 Frequent absence

Col.41/Y A) Emotional Stability
/X B)
/0 C)
/1 D)
/2 E)
/3 A) Temper
/4 B)
/5 C)
/6 D)
/7 E)
/8 Persistent or frequent lateness
/9 Dirty and untidy

Col.42/Y A) Emotionally dependent
/X B)
/0 C)
/1 D)
/2 E)
/3 A) Conc.
/4 B)
/5 C)
/6 D)
/7 E)
/8 Inadequately dressed
/9 "Additional" behaviour

Col.43/Y A) Leadership
/X B)
/0 C)
/1 D)
/2 E)
/3 A) Agress.
/4 B)
/5 C)
/6 D)
/7 E)
/8 Listed behaviour
/9 Occ. daydreaming.

Col.44/Y A) Order
/X B)
/0 C)
/1 D)
/2 E)
/3 A) Friendly
/4 B)
/5 C)
/6 D)
/7 E)
/8 No form
/9 Attending R.C. school.

Cols.45-63 Behaviour symptoms.

Col.64/Y Full discussion of facts of life.
/X Invited discussion or answering of questions.
/0 No discussion.
/1 Periods only.
/2 Many friends.
/3 Few friends.
/4 1-2 friends.
/5 No real friends.
/6 Much older friends.
/7 Older "
/8 Same age "
/9 Younger "

Col.65/Y Much younger friends.
/X Never changes friends.
/0 Occasional changes.
/1 Often changes friends.
/2 Friends brought home often
/3 " " " occasionally.
/4 " " " never
/5 Mother prefers friends to come.
/6 Wants to be boss.
/7 Joins in.
/8 Easily led, a follower.
/9 Sociable to visitors.

Col.66/Y Indifferent to visitors
/X Unsociable to visitors
/0 Shows off to visitors
/1 Youth Orgns. Regular membership.
/2 " " Abortive "
/3 " " None
/4 Never goes to cinema
/5 Cinema 1 per week
/6 " 1 per week
/7 " 2 per week
/8 " 3 per week
/9 T.V. Own set Yes.

Col.67/Y T.V. Own set No
/X Rarely
/0 1
/1 1-2 T.V. viewing
/2 3 hrs. +
/3 None
/4 Irregular Pocket
/5 2/6d. money
/6 2/6d. to 5/-
/7 5/-
/8 Spont. regular saving
/9 No real hobbies.

Col.68/Y Hobbies, 'playing games, etc.'
/X Handicrafts, collecting, etc.
/0 Gets on with father very well.
/1 " " " well
/2 " " " fair
/3 " " " poor
/4 " " " badly
/5 " " mother very well
/6 " " " well
/7 " " " fair
/8 " " " poor
/9 " " " badly

Col.69/Y Fathers boy
/X Mothers boy
/0 Frequently helps in house
/1 Infrequently helps in house
/2 Never helps in house
/3 Family get out a great deal
/4 " " " quite often
/5 " " " now and then
/6 " " " seldom
/7 " " " almost never
/8 Father plays a great deal
/9 " " quite often

Col.70/Y Father plays now and then
/X " " seldom
/0 " " almost never
/1 Rgds.famy as M.respons.
/2 " " as jnt. "
/3 " " his "
/4 Takes child out frequ.
/5 Takes child out infrequ.
/6 Never takes child out.
/7 Punish.mainly deprivation
/8 " " smacking
/9 " causes disagree.

Col.71/Y B.P. before 5 years
/X N
/0 T.B.P.
/1 P.B.P.
/2 Persistence after 5 yrs.
/3 After 5 years N
/4 T.B.P.
/5 P.B.P.
/6 Current abnormality
/7 Attended psychiatrist
/8 Attended non-psych.spec.
/9 Attended G.P.

Col.72/Y Death of F.in 1st year.
/X " " F.in 2nd "
/0 " " F.in 3rd "
/1 " " F.in 4th "
/2 " " F.in 5th "
/3 " " F.subsequent
/4 " " M.in 1st year
/5 " " M.in 2nd "
/6 " " M.in 3rd "
/7 " " M.in 4th "
/8 " " M.in 5th "
/9 " " M.subsequent

Col.73/Y Divorce
/X Desertion
/0 Legal separation
/1 StepMother
/2 StepFather
/3 Other symptoms not listed
/4 " before 5
/5 " after 5
/6 Sleepwalking
/7 "Spoilt"
/8
/9

Col.74/Y Own room
/X Own bedroom shared children of same sex.
/0 ditto opposite sex.
/1 Shared bed, same sex.
/2 " bed, opp. sex.
/3 " bed, parent or other adult.
/4 " room "
/5 1 or less } crowding level
/6 1-1½ } persons per
/7 1½-2 } room
/8 More than 2 }
/9

Col.75/Y Grammar } grading
/X Tech. } exam
/0 Comm. } choice
/1 Sec.mod. }
/2 F. working away from home
/3 Child in family living with relatives.
/4
/5
/6
/7
/8
/9

A P P E N D I X 4

A INTERSYMPTOM CORRELATIONS

B SEX DIFFERENCES IN SYMPTOM FREQUENCY

APPENDIX 4A

The distribution of symptoms in the maladjusted group was examined with a view to determining whether particular symptoms were more indictive of maladjustment than others and whether symptom groups or syndromes could be identified. In the present study the prevalence of each symptom in the maladjusted and control groups has been compared using the chi-squared method (Table 3). Although it is generally agreed that chi-squared does not measure the degree of association (Fisher, 1941) each calculation involved one degree of freedom and was between groups of constant size. It seemed possible that in these circumstances the magnitude of chi-squared might reflect the degree of association.

With these aims in mind, intersymptom correlations were calculated between thirty symptoms occurring in the maladjusted group (Table 1). Significant associations were found between a number of symptoms, as discussed in the text, but no clear groupings or syndromes emerged.

To determine the relative importance of individual symptoms two methods were attempted. In the first a coefficient of correlation between the total intersymptom correlations and the chi-squared values for the thirty symptoms was calculated. This coefficient was statistically significant ($r = 0.48$) and suggests that there is an association between the chi-squared values and maladjustment. Secondly, first factor loadings were calculated (Table 2) and these may give some indication of the relative importance of the various symptoms. The three symptoms with the highest factor loading (over 0.5) were overactivity, irritability and emotional dependance.

→ Number of children with other symptom.

Symptom	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30
1	**26**	4	6	4	2	11	12	3	7	15	12	5	5	9	7	7	17	17	11	18	14	13	12	10	12	10	15	11	12	0
2	+·085	**13**	7	5	5	5	7	1	4	9	7	3	2	4	4	3	6	10	5	8	5	6	8	4	6	5	7	4	5	0
3	−·036	+·213	**33**	6	4	11	12	2	8	21	9	8	5	7	8	7	21	17	11	17	16	12	14	10	16	9	16	12	10	1
4	−·018	+·148	+·024	**21**	4	2	14	1	3	9	3	6	2	6	7	5	13	10	10	13	9	5	10	5	4	6	13	9	4	0
5	−·032	+·334	+ 053	+·145	**12**	4	9	0	3	8	3	1	2	4	3	3	5	6	7	6	8	3	6	4	4	4	10	5	3	1
6	+·116	+·049	+ 020	− 213	+ 011	**40**	11	4	10	25	17	8	8	12	5	9	17	24	15	23	14	16	15	10	14	10	27	13	13	3
7	+·129	+·141	+ 028	+ 306	+·280	− 095	**43**	3	12	26	11	11	9	14	11	13	26	26	20	27	17	18	20	16	14	11	27	17	18	1
8	+·087	+ 007	− 025	− 041	− 090	+ 076	− 065	**9**	3	7	3	0	0	1	1	2	4	6	2	5	3	6	6	3	6	1	1	1	1	1
9	+·102	+·101	+ 074	−·054	+·049	+ 103	+ 162	+·101	**24**	19	10	7	8	6	5	10	12	14	5	17	8	13	10	7	8	4	12	7	10	2
10	+·119	+·158	+ 210	− 028	+·134	+ 225	+·208	+·177	+·322	**58**	22	14	12	16	13	15	31	33	20	39	25	29	34	20	26	14	36	18	26	4
11	+·209	+·197	− 007	− 135	−·020	+·224	−·035	+·034	+·150	+·209	**35**	10	13	12	12	7	18	20	8	23	17	17	18	12	18	8	21	8	17	0
12	+·013	+·062	+ 092	+·119	−·083	+ 031	+·137	−·131	+·137	+·141	+·166	**23**	7	12	8	9	13	16	9	15	7	13	9	7	12	6	14	5	9	0
13	+·072	+·011	+ 015	−·061	+·022	+·111	+·137	− 113	+·264	+·169	+·405	+·218	**18**	8	9	5	8	11	5	13	2	8	9	5	7	3	11	5	9	0
14	+·141	+ 062	− 026	+·059	+ 080	+ 113	+ 168	−·078	+ 023	+·100	+·166	+ 327	+·209	**29**	13	8	19	21	12	19	15	12	17	12	14	10	23	9	14	0
15	+ 048	+·077	+ 041	+·130	+·028	−·148	+ 073	− 070	−·007	+·022	+·194	+·154	+ 284	+·312	**27**	8	19	14	9	17	14	13	13	10	15	10	20	9	11	1
16	+ 102	+·035	+ 033	+·054	+·049	+·060	+·205	+ 022	+·279	+·160	+·015	+·242	+·091	+ 119	+ 141	**24**	18	14	13	18	12	14	9	8	13	6	16	7	4	2
17	+ 232	+·023	+ 250	+·172	−·008	−·066	+ 256	+ 009	+ 070	+·198	+·167	+ 130	+ 013	+ 256	+ 290	+·315	**54**	34	26	37	28	26	25	21	24	20	36	25	20	1
18	+·173	+·194	+ 037	−·007	+ 010	+·158	+ 174	+ 101	+·076	+·157	+·109	+ 200	+·104	+ 263	+ 229	+ 096	+·252	**61**	26	35	25	26	28	16	26	19	40	22	25	5
19	+·116	+·049	+ 020	+ 152	+ 185	+·064	+ 228	− 057	−·114	+ 054	+·118	+·075	− 035	+·113	+ 018	+ 234	+ 305	+·226	**40**	23	25	14	15	14	18	15	29	20	13	1
20	+·196	+ 078	+ 018	+ 106	000	+ 102	+ 184	+ 031	+ 202	+·318	+·195	+ 144	+ 181	+ 170	+·135	+ 243	+ 321	+·143	+ 102	**63**	28	33	34	20	27	17	41	16	28	4
21	+ 148	−·008	+·107	+ 029	+·179	+ 169	− 002	− 036	− 062	+·065	+·113	− 089	− 238	+ 135	+ 138	+ 102	+ 215	+ 226	+ 318	+ 097	**50**	21	22	22	23	13	37	16	15	2
22	+·161	+·080	+ 068	−·104	− 068	+ 073	+ 165	+ 185	+ 196	+·292	+·178	+ 214	+ 082	+ 074	+ 146	+ 236	+ 260	+ 157	+ 001	+ 366	+ 120	**44**	28	22	26	9	29	8	20	3
23	+·102	+·176	+ 078	+ 103	+·091	+ 014	+ 150	+ 174	+ 062	+ 424	+ 192	+ 026	+ 114	+ 251	+ 126	+ 140	+ 176	+ 189	+ 014	+ 363	+ 126	+ 413	**46**	20	25	13	34	12	25	1
24	+·142	+·035	+ 056	−·024	+ 053	−·018	+ 160	+ 045	+ 033	+ 174	+ 114	+ 046	+ 015	+ 169	+ 129	+ 079	+ 250	+ 001	+ 137	+ 127	+ 329	+ 397	+ 298	**33**	23	9	27	9	14	0
25	+·085	+·056	+ 127	−·175	− 032	− 043	− 062	+ 163	− 048	+ 128	+ 170	+ 137	+ 007	+ 115	+ 188	+ 161	+ 113	+ 040	+ 097	+ 048	+ 132	+ 317	+ 254	+ 388	**48**	16	33	12	20	1
26	+·212	+·141	+ 085	+ 078	+ 094	+ 059	+ 073	− 070	− 056	+ 061	+ 022	+ 054	− 047	+ 174	+ 199	+ 042	+ 329	+ 229	+ 247	+ 135	+ 090	− 017	+ 126	+ 085	+ 228	**27**	24	17	15	1
27	−·011	− 034	− 124	+ 029	+ 162	+ 121	+ 059	− 268	− 084	+ 063	+ 016	+ 021	+ 020	+ 229	+ 163	+ 078	+ 140	+ 135	+ 191	+ 129	+ 252	+ 107	+ 234	+ 279	+ 160	+ 320	**74**	26	29	2
28	+·165	+ 023	+ 114	+ 151	+ 101	+ 072	+ 189	− 183	+ 015	+ 047	− 048	− 064	000	+ 060	+ 065	+ 015	+ 358	+ 179	+ 338	− 053	+ 076	− 157	− 029	− 007	− 069	+ 410	+ 196	**35**	13	1
29	+ 178	+ 064	+ 002	− 108	− 036	+ 035	+ 184	− 115	+ 122	+ 295	+ 249	+ 092	+ 176	+ 216	+ 120	− 143	+ 130	+ 226	+ 035	+ 311	− 003	+ 244	+ 400	+ 159	+ 197	+ 289	+ 235	+ 094	**38**	0
30	− 104	− 061	− 029	− 091	+ 073	+ 123	− 041	+ 101	+ 108	+ 139	− 126	− 098	− 083	− 111	− 007	+ 108	− 094	+ 210	− 057	+ 121	+ 001	+ 107	− 070	− 121	− 028	− 007	− 077	− 035	− 134	**5**
Mean number of other symptoms.	10·8	11·46	9·18	8·9	10·58	9·02	10·06	8·5	10·16	10·1	10·17	10·6	10·41	11·34	10·88	11·84	10·55	9·68	10·02	9·85	9·36	10·52	10·78	10·9	9·45	11·29	8·86	9·62	10·6	7·6
(10·1)																														

correlation coefficient

Total number of children with each symptom shown in diagonal.

CORRELATION MATRIX : THIRTY SYMPTOMS (MALADJUSTED GROUP ONLY)

TABLE 2

Key to Symptoms

1. Diurnal restlessness
2. Diurnal enuresis
3. Nocturnal enuresis
4. Inadequate appetite
5. Soiling
6. Tics
7. Food fads
8. Thumb sucking
9. Wandering
10. Overactivity
11. Lying
12.* Destructiveness
13. Stealing
14.* Quarrelling
15. Sharing
16. Unselfreliance
17.* Emotional dependence
18.* Adventurousness
19. Shyness
20. Temper
21. Fears
22. Disobedience
23. Irritability
24. Attention demanding
25. Jealousy
26. Depression
27. Sensitivity
28. Reserve
29. Instability of mood
30. Masturbation

* both extremes of rating scale included

	Total r.	1st. factor loading		Total r.	1st. factor loading		Total r.	1st. factor loading
1.	2.952	0.37	11.	2.924	0.37	21.	2.460	0.32
2.	2.515	0.33	12.	2.495	0.33	22.	4.164	0.48
3.	1.468	0.23	13.	2.142	0.29	23.	4.572	0.52
4.	0.796	0.17	14.	3.877	0.45	24.	3.569	0.43
5.	1.764	0.26	15.	3.229	0.39	25.	2.906	0.36
6.	1.567	0.24	16.	3.185	0.39	26.	3.605	0.43
7.	3.471	0.42	17.	5037	0.56	27.	2.739	0.35
8.	0.111	0.10	18.	4.158	0.48	28.	2.103	0.29
9.	2.338	0.31	19.	2.984	0.37	29.	3.513	0.42
10.	4.761	0.54	20.	4.563	0.52	30.	-0.350	0.06

r (with 1 in diagonal) = 115.62

$\sqrt{\Sigma r}$ = 10.75 $1/\sqrt{\Sigma r}$ = 0.09302

TABLE 3

*	20.9	-	Physical timidity plus adventurousness
‡	20.8	-	Motor overactivity
‡	18.6	-	Soiling
*	15.9	-	Quarrelling and refusal to defend self
‡	15.2	-	Wandering
‡	14.9	-	Diurnal enuresis
	12.5	-	Excess shyness
*	(12.1)		(Physical timidity)
*	12.0	-	Overdependance and independance
	11.1	-	Temper tantrums
	(10.9)		(Quarrelling) P <0.001
*	10.3	-	Destructiveness and excess care
	10.2	-	Jealousy
	9.8	-	Irritability
	9.4	-	Disobedience
	8.5	-	tics
	8.4	-	Instability of mood
	8.2	-	Attention demanding
	7.5	-	Excess reserve
	7.5	-	Sadness or depression
	(7.5)		(Overdependance)
	7.1	-	Inadequate appetite
	7.1	-	Nocturnal enuresis
	6.7	-	Food fads
	6.6	-	Nocturnal restlessness
	6.6	-	Lack of self reliance P <0.01
	6.3	-	Lying
	6.2	-	Stealing
	6.0	-	Fears P <0.02
‡	(5.2)		(Destructiveness)
‡	4.6	-	Masturbation
	4.5	-	Sensitivity
*	4.3	-	Reluctance to share plus excessive generosity
	(4.0)		(Reluctance to share) P <0.05
‡	2.9	-	Thumb sucking
	2.7	-	Nightmares
	2.4	-	Nailbiting
	1.6	-	Modesty
	1.3	-	Truancy
	0.8	-	Competitiveness

* both extremes of rating scale included

‡ X^2 based on small numbers

APPENDIX 4B

Sex Differences in Symptom Frequency

The maladjusted group and the combined control and maladjusted/control group (population estimate) are listed separately. Each symptom frequency is expressed as a percentage and the standard error of the difference is calculated from

$$\text{s.e. diff.} = \sqrt{P.Q.\left(\frac{1}{N_1} + \frac{1}{N_2}\right)} \quad \text{where } Q = 100-P$$

A difference exceeding twice the standard error is regarded as significant.

MALADJUSTED GROUP

Symptom	Male	Female	Combined(P)	Difference	Standard Error	Diff s.e.
Disturbing dreams	15.8	10.0	13.5	5.8	6.22	
Nocturnal restlessness	22.4	18.0	20.6	4.4	7.36	
Difficulty in waking	13.2	10.0	11.9	3.2	9.43	
Insomnia	19.7	28.0	23.0	8.3	7.66	
Sleep walking	10.5	10.0	10.3	0.5	5.53	
Nocturnal enuresis	27.6	24.0	26.2	3.6	8.01	
Diurnal enuresis	9.2	12.0	10.3	2.8	5.53	
Soiling	14.5	2.0	9.5	12.5	5.34	2.34
Inadequate appetite	17.1	16.0	16.7	1.1	6.79	
Excessive appetite	7.9	10.0	8.7	2.1	5.13	
Food fads	36.8	30.0	34.0	6.8	8.44	
Tics	40.8	18.0	31.7	22.8	8.47	2.69
Nailbiting	38.1	38.0	38.0	0.1	8.83	
Thumb sucking	5.3	10.0	7.0	4.7	4.64	
Overactivity	51.3	38.0	46.0	13.3	9.07	
Wandering	28.9	4.0	19.0	24.9	7.14	3.49
Truancy	11.8	6.0	9.5	5.8	5.34	
Lying	26.3	30.0	27.8	3.7	8.15	
Stealing	21.0	4.0	14.3	17.0	6.37	2.67
Destructiveness	17.1	6.0	12.7	11.1	6.06	
Excessive care of prop.	4.0	8.0	5.6	4.0	4.19	
Reluctance in sharing	17.1	10.0	14.3	7.1	6.37	
Excessive generosity	6.6	8.0	7.1	1.4	4.68	
Quarrelsomeness	14.5	14.0	14.3	0.5	6.37	
Refusal to defend self	9.2	8.0	8.7	1.2	5.13	
Emotional dependance	34.2	30.0	32.5	4.2	8.52	
Extreme independance	11.8	10.0	11.1	1.8	5.72	
Unselfreliance	23.7	12.0	19.1	11.7	7.15	
Shyness	30.2	34.0	31.7	3.8	8.47	

Symptom	Male	Female	Combined (P)	Difference	Standard Error	Diff/s.e.
Physical timidity	32.9	36.0	34.1	3.1	8.63	
Overadventurousness	19.7	6.0	14.3	13.7	6.37	2.15
Fears	34.2	48.0	39.7	13.8	8.90	
Temper	51.3	48.0	50.0	3.3	9.10	
Irritability	39.5	32.0	36.5	7.5	8.76	
Disobedience	36.8	32.0	34.9	4.8	8.68	
Jealousy	32.9	46.0	38.1	13.1	8.84	
Attention demanding	22.4	32.0	26.2	9.6	8.01	
Undue sensitivity	63.1	52.0	58.7	11.1	8.96	
Depression	19.7	24.0	21.4	4.3	7.46	
Instability of mood	27.6	34.0	30.2	6.4	8.36	
Excess reserve	30.3	24.0	27.8	6.3	8.15	
Excessively competitive	26.3	24.0	25.4	2.3	7.92	
Modesty	32.9	32.0	32.5	0.9	8.53	
Masturbation	6.6	NIL	4.0	6.6	3.57	

POPULATION ESTIMATE

Symptom	Male	Female	Combined (P)	Difference+	Standard Error	Diff/S.e.
Disturbing dreams	2.7	13.2	7.1	10.5	4.6	2.28
Nocturnal restlessness	8.1	13.2	10.2	5.1	5.42	
Difficulty in waking	12.2	17.0	14.2	4.8	6.25	
Insomnia	14.9	13.2	14.2	1.7	6.25	
Sleep walking	4.1	11.3	7.1	7.2	4.6	
Nocturnal enuresis	12.2	7.5	11.0	4.7	5.73	
Diurnal enuresis	1.4	5.7	3.2	4.3	3.15	
Soiling	5.4	NIL	3.2	5.4	3.15	
Inadequate appetite	5.4	15.1	9.5	9.7	5.25	
Excessive appetite	8.1	9.4	8.7	1.3	5.04	
Food fads	14.9	26.4	19.7	11.5	7.12	
Tics	17.6	15.1	16.5	2.5	6.64	
Nailbiting	31.1	35.8	33.1	4.7	8.42	
Thumb sucking	2.7	5.7	3.9	3.0	3.47	
Overactivity	29.7	17.0	24.4	12.7	7.69	
Wandering	9.5	NIL	5.5	9.5	4.08	2.33
Truancy	10.8	NIL	6.3	10.8	4.35	2.48
Lying	21.6	11.3	17.3	10.3	6.77	
Stealing	12.2	NIL	7.1	12.2	4.6	2.65
Destructiveness	9.5	NIL	5.5	9.5	4.08	2.33
Excessive care of prop.	NIL	1.9	0.8	1.9	1.59	
Reluctance in sharing	8.1	5.7	7.1	2.4	4.6	
Excessive generosity	4.1	11.3	7.1	7.2	4.6	
Quarrelsomeness	6.8	NIL	3.9	6.8	3.47	(1.96)
Refusal to defend self	2.7	3.8	3.2	1.1	3.15	
Emotional dependance	25.7	22.6	24.4	3.1	7.69	
Extreme independance	6.8	NIL	3.9	6.8	3.47	(1.96)
Unselfreliance	13.5	11.3	12.6	2.2	5.94	
Shyness	17.6	22.6	15.0	6.3	6.39	
Physical timidity	17.6	22.6	19.7	5.0	7.12	
Overadventurousness	9.5	NIL	5.5	9.5	4.08	2.32
Fears	20.3	37.7	27.6	17.4	8.00	2.18
Temper	36.5	22.6	30.7	13.9	8.26	
Irritability	17.6	18.9	18.1	2.3	6.89	
Disobedience	28.4	13.2	22.1	15.2	7.43	2.05
Jealousy	21.6	26.4	23.6	4.8	7.6	
Attention demanding	13.5	13.2	13.4	0.3	6.1	
Undue sensitivity	54.0	43.4	49.4	6.2	8.95	
Depression	9.5	7.5	8.7	1.2	5.04	
Instability of mood	17.6	15.1	16.5	1.4	6.65	
Excess reserve	14.9	13.2	14.2	1.0	6.25	
Excessively competitive	24.3	18.9	22.1	3.?	7.43	
Modesty	29.7	24.5	27.6	3.1	8.0	
Masturbation	1.4	NIL	0.8	0.8	1.59	

A P P E N D I X 5

A HEIGHTS AND WEIGHTS

B GRADING EXAMINATION RESULTS

C SCHOOL ATTAINMENT

D PERSONALITY TRAITS

E SOCIAL GROUPS

F RESPIRATORY INFECTIONS

HEIGHTS AND WEIGHTS

Weight at 3 yrs. (pounds)	Maladjusted Group		Control Group		
	Full Group	Non Enuretics	Full Group	Non Enuretics	Severe Group
24	4	1	2	2	5
25	2	1	1	1	1
26	5	3	3	3	5
27	4	1	1	0	4
28	10	8	3	3	9
29	7	5	9	7	4
30	5	3	9	8	3
31	10	8	12	7	4
32	10	6	4	4	8
33	9	7	5	3	6
34	6	3	4	4	4
35	8	6	3	3	6
36	0	0	3	2	0
37	4	1	4	4	2
38	1	1	6	6	1
39	2	0	0	0	1
40	0	0	0	0	0
41	1	1	0	0	0
42	3	1	0	0	1
43	1	1	1	1	0
Total No. (Mean weight)	92(31.54)	57(31.47)	70(31.8)	58(31.97)	64(30.59)

Height at 3 yrs. (inches)					
32	3	0	3	2	5
33	4	3	2	2	6
34	11	9	10	9	7
35	12	7	9	6	8
36	20	14	18	13	15
37	19	12	17	16	11
38	15	9	7	6	7
39	2	1	3	3	0
40	2	1	2	2	1
Total No. (Mean height)	88(36.06)	56(36.05)	71(36.01)	59(36.12)	60(35.48)

	Maladjusted Group		Control Group		
Weight at 5 yrs (pounds)	Full Group	Non Enuretics	Full Group	Non Enuretics	Severe Group
30	1	0	0	0	1
31	1	0	0	0	1
32	0	0	0	0	0
33	2	2	2	2	2
34	4	4	2	2	3
35	4	2	0	0	2
36	5	5	3	3	3
37	3	3	4	2	5
38	7	3	5	4	4
39	4	0	7	5	3
40	7	4	6	6	6
41	7	2	3	1	6
42	1	0	6	6	1
43	7	6	9	6	3
44	5	4	6	5	1
45	8	5	5	5	7
46	4	1	7	6	4
47	5	2	2	2	2
48	3	2	2	2	2
49	2	2	1	1	2
50	0	0	2	2	0
51	3	0	1	1	1
52	1	1	1	0	0
53	2	1	0	0	1
54	1	0	0	0	0
55	0	0	0	0	0
56	0	0	1	1	0
65	0	0	1	1	0
Total No. (Mean weight)	87(41.75)	49(41.16)	76(42.49)	63(42.63)	60(40.88)

Height at 5 yrs (inches)					
38	3	0	0	0	3
39	6	3	3	3	5
40	5	3	4	3	4
41	16	8	10	8	13
42	10	7	12	7	8
43	0	14	17	14	9
44	17	5	7	5	10
45	6	12	13	12	3
46	4	3	3	3	3
47	3	3	3	3	1
48	1	2	2	2	1
49	0	0	0	0	0
Total No. (Mean weight)	71(42.46)	48(42.46)	74(43.11)	60(43.27)	60(42.22)

	Maladjusted Group		Control Group		
Weight at 9 yrs (pounds)	Full Group	Non Enuretics	Full Group	Non Enuretics	Severe Group
41	0	0	1	1	0
45	5	4	3	2	4
46	1	0	0	0	0
47	1	1	2	2	1
48	4	1	2	2	5
49	11	8	5	5	8
50	6	6	4	4	4
51	4	3	2	2	3
52	7	4	4	3	3
53	2	1	2	1	0
54	4	1	3	2	3
55	6	3	3	2	6
56	12	7	8	5	10
57	2	1	3	3	2
58	1	0	7	6	3
59	4	4	6	4	1
60	6	4	5	4	5
61	4	2	3	1	1
62	2	1	5	4	1
63	7	6	7	6	3
64	4	2	6	6	2
65	5	3	4	5	3
66	5	2	5	4	3
67	4	4	0	0	2
68	3	3	0	2	2
69	1	0	2	2	0
70	3	1	2	2	0
71	0	0	1	1	0
72	3	1	2	2	3
74	0	0	1	1	1
75	1	1	0	0	1
77	1	1	0	0	0
79	0	0	1	0	0
80	1	0	0	0	0
84	1	0	1	1	2
85	0	0	1	1	0
86	1	1	0	0	1
96	0	0	1	1	0
Total No. (Mean weight)	122(58.18)	76(57.82)	102(59.33)	85(59.55)	83(57.7)

Height at 9 yrs (inches)	Maladjusted Group: Full Group	Maladjusted Group: Non Enuretics	Control Group: Full Group	Control Group: Non Enuretics	Control Group: Severe Group
43	1	0	0	0	1
44	0	0	1	1	0
45	6	4	2	2	7
46	7	2	5	4	3
47	10	7	6	5	7
48	12	10	12	9	10
49	19	11	13	12	19
50	11	8	18	14	4
51	22	13	20	15	12
52	17	12	9	8	11
53	6	3	8	7	5
54	7	4	2	2	1
55	3	1	4	4	3
56	0	0	0	0	0
57	0	0	0	0	0
58	0	0	1	1	0
Total No. (Mean height)	121(49.83)	75(49.83)	101(50.07)	84(50.13)	83(49.45)

GRADING EXAMINATION RESULTS

Intelligence quotient (Mean of two Moray House Tests)

I.Q.	Maladjusted	Control	Severe
84	37	16	33
85-89	10	10	9
90-94	6	13	3
95-99	13	12	8
100-104	18	11	10
105-109	13	13	4
110-114	12	10	6
115-119	5	8	0
120-124	4	4	3
125-129	0	1	0
130-134	0	1	0
135	1	0	1
Mean I.Q.	96.62	99.58	93.05

Arithmetic quotient

A.Q.	Maladjusted	Control	Severe
84	21	12	16
85-89	15	5	16
90-94	15	11	9
95-99	11	9	6
100-104	15	14	10
105-109	13	16	8
110-114	12	10	5
115-119	6	15	3
120-124	6	3	1
125-129	3	2	1
130-134	1	1	1
135	1	1	1
Mean A.Q.	99.35	103.11	96.35

GRADING EXAMINATION RESULTS

English quotient

E.Q.	Maladjusted	Control	Severe
84	28	13	28
85-89	12	9	7
90-94	9	7	9
95-99	14	16	8
100-104	16	12	8
105-109	15	14	7
110-114	12	8	3
115-119	8	9	5
120-124	1	5	0
125-129	2	5	1
130-134	1	1	0
135	1	0	1
Mean E.Q.	98.22	101.05	96.35
No. of children	119	99	77

SCHOOL REPORT FORM

Teachers assessment of ability in school subjects

A = above average
B = average
C = below average
Discrepancy = Rating for attainment or application differs from rating for ability

		Maladjusted	Control	Severe
Reading	A	27	24	13
	B	62	57	40
	C	27	19	28
	Discrepancy	36	27	27
Arithmetic	A	13	15	7
	B	51	48	33
	C	51	36	41
	Discrepancy	28	31	20
English	A	15	15	7
	B	57	52	33
	C	44	32	41
	Discrepancy	30	30	25
Art	A	7	7	6
	B	59	62	32
	C	47	31	42
	Discrepancy	31	26	21
Games	A	7	11	3
	B	79	65	46
	C	29	19	29
	Discrepancy	29	17	18
Specific difficulty in a school subject		27	13	23

TRAIT RATINGS

See Appendix 2.

Rating		Maladjusted	Control	Severe
Emotional stability	A	5	1	4
	B	14	12	10
	C	79	78	49
	D	12	8	13
	E	5	1	5
Temper	A	1	0	1
	B	6	5	5
	C	64	67	45
	D	37	22	22
	E	7	6	8
Emotional dependance	A	1	1	1
	B	14	14	13
	C	58	57	33
	D	39	28	28
	E	4	0	6
Concentration	A	1	1	0
	B	16	12	8
	C	56	51	33
	D	30	31	26
	E	13	5	14
Leadership	A	2	1	1
	B	10	9	3
	C	37	42	24
	D	52	41	36
	E	14	7	17
Aggressiveness	A	0	1	1
	B	15	5	12
	C	39	31	24
	D	52	61	35
	E	9	2	9
Obedience	A	0	1	1
	B	12	7	12
	C	39	32	30
	D	50	51	26
	E	14	9	12
Friendliness	A	2	1	0
	B	14	17	9
	C	74	63	50
	D	23	19	19
	E	1	0	3

Social Group	Father				Mat. Grandfather				Pat. Grandfather			
	Maladjusted	Control	Mal./Con.	Severe	Maladjusted	Control	Mal./Con.	Severe	Maladjusted	Control	Mal./Con.	Severe
A. Professional	2	1	0	0	2	0	0	1	2	1	0	1
B. Employer	2	1	0	1	3	0	0	2	0	1	0	0
C. Salaried	10	4	0	4	2	3	1	1	1	3	1	2
D. Blackcoated	7	7	3	5	7	6	0	4	6	1	1	5
E. Skilled Manual	49	48	7	33	58	49	7	36	48	48	7	30
F. Semi Skilled Manual	38	21	4	24	22	17	4	16	29	12	4	21
G. Unskilled Manual	13	16	4	15	20	15	8	17	14	14	5	15
H. Agricultural	0	0	0	0	1	2	0	0	2	1	0	1
I. Self Employed	4	1	2	2	2	6	2	2	9	6	3	5
Not Recorded	1	6	2	4	9	7	0	9	15	19	1	8
Total	126	105	22	88	126	105	22	88	126	106	22	88

Fathers 3×2 table for (A,B,C), (D), (E,F,G,H) Mal. vs. Control $\chi^2 = 1.8$ with 3 D.F. Not sig.
Mat. G/father. - - - - - - - - $\chi^2 = 2.1$ " - - "
Pat. G/father. - - - " " " - " $\chi^2 = 2.4$ " - - "

Social Groups (after Douglas and Blomfield)

APPENDIX 5F

Respiratory Infections up to Age Five Years

All Respiratory Infections

Includes pneumonia, bronchitis, tonsillitis, unclassified disease and severe colds causing constitutional disturbance.

Total No.	Maladjusted	Control	Mal./Con.	Severe
0	3	6	0	2
1	6	11	3	7
2	12	24	2	9
3	24	13	4	16
4	13	13	1	6
5	24	7	1	15
6	14	7	5	12
7	12	7	4	9
8	6	7	1	5
9	7	1	1	3
10	3	1	0	2
11	1	2	0	1
12	0	2	0	0
13	0	1	0	0
14	0	0	0	0
15	0	1	0	0
Not recorded	1	2	0	1

Severe Respiratory Infections (pneumonia and bronchitis)

0	59	58	10	39
1	38	24	8	29
2	15	12	4	12
3	8	4	0	3
4	4	4	0	3
5	0	1	0	0
6	1	0	0	1
Not Recorded	1	2	0	1

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